HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ____ ____ ____ Last 4 #SSN ___ ___ ___ ___ Gender M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A Check One — Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Check One — Medical Interventions: Person has pulse and/or is breathing.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

C Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with:
☐ Patient ☐ Parent of Minor
☐ Legal Guardian ☐ Health Care Agent (DPOAHC)
☐ Spouse/Other:

PRINT — Physician/ARNP/PA-C Name | Phone Number

✗ Physician/ARNP/PA-C Signature ***(mandatory)*** | Date

PRINT — Patient or Legal Surrogate Name | Phone Number

✗ Patient or Legal Surrogate Signature ***(mandatory)*** | Date

Person has: ☐ Health Care Directive (living will) ☐ Living Will Registry ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 2/2011

Photocopies and FAXes of signed POLST forms are legal and valid. May make copies for records

Washington State Medical Association WSMA — Physician Driven Patient Focused

Washington State Department of Health

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Other Contact Information (Optional)

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

D Additional Patient Preferences (optional)

Antibiotics:

☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

Medically Assisted Nutrition:

Always offer food and liquids by mouth if feasible.

☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ No medically assisted nutrition by tube.
☐ Long-term medically assisted nutrition by tube.

Additional Orders: (e.g. dialysis, blood products, etc. Attach additional orders if necessary.)

✗ Physician/ARNP/PA-C Signature	Date

Directions for Health Care Professionals

Completing POLST

- Must be completed by health care professional.
- Should reflect person's current preferences and medical indications. Encourage completion of an advance directive.
- POLST must be signed by a physician/ARNP/PA-C to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is effective across all settings including hospitals until replaced by new physicians's orders.

The health care professional should inquire about other advance directives. In the event of a conflict, the most recently completed form takes precedence.

SECTION A:
- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:
- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

A person with capacity or the surrogate of a person without capacity, can void the form and request alternative treatment.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

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