Do Not Resuscitate (DNR) and Other Patient-Designated Directives

Emergency Medical Services Authority
California Health and Human Services Agency

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EMS Personnel Guidelines Limiting Pre-Hospital Care

HOWARD BACKER, MD, MPH, FACEP
DIRECTOR

DANIEL R. SMILEY
CHIEF DEPUTY DIRECTOR

SEAN TRASK
DIVISION CHIEF

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INTRODUCTION

These guidelines are intended to assist local emergency medical services (EMS) agencies in developing policies that honor patient-designated choices regarding unwanted resuscitation attempts and other out-of-hospital interventions. These policies allow patients to refuse resuscitation and medical interventions and ensure that a patient's rights are honored.

Local decision-making is essential in this sensitive area. When developing these policies, the local EMS agency should ensure that all stakeholders (providers, interested groups and individuals) have an opportunity to provide input during the process. Most importantly, non-EMS physicians and their patients must be aware of these policies and the ability to limit prehospital care options.

BACKGROUND

The goals of emergency medical services personnel include saving lives, preventing disability and relieving suffering. Historically, EMS systems focused on sudden cardiac death and resuscitation. Patients were treated to the fullest extent possible, and discussions about patients' wishes regarding resuscitation or the extent of treatment were reserved for medical personnel in acute care facilities.

More frequently, patients or their families resist resuscitative measures. These patients are generally, although not always, victims of terminal illnesses, and are encountered in skilled nursing facilities, private residences and other care settings. They may or may not be hospice clients. They view resuscitation attempts as lacking sufficient benefit and merely prolonging the process of dying, while causing unnecessary discomfort and emotional distress.

Historically, emergency responders were obligated to initiate full resuscitative measures and these were usually continued until arrival at a hospital. Discouraging patients from using the EMS system when they do not wish resuscitation avoids difficult problems, including identification issues, but may deny patients palliative treatment, an important obligation of all health care providers. In some cases, these patients must use the EMS system solely to obtain transportation, sometimes forcing them to accept unwanted resuscitative measures.

Despite pre-planning to decline resuscitation, family members and employees of health or long-term care facilities may activate 9-1-1 when death is imminent. Performing resuscitation against a patient's wishes in this case is inappropriate because it denies them real authority over their health care.

While it is clear that care givers should acknowledge patients' wishes in regard to resuscitation, caution is needed in the field setting since there is generally no established relationship between the patient and emergency responder. Specific procedures are needed whereby patient directives regarding limited care will be respected in the home and long term care facility and during transport. This is best

dealt with by standard requirements for DNR directives and clearly written policies and procedures for local EMS providers.

Cardiopulmonary resuscitation is similar to other medical interventions with advantages and disadvantages, risks and benefits. When possible, patients should give informed consent before resuscitation is attempted; however, in cases of sudden, unexpected cardiac arrest, treatment consent is not possible, so EMS systems operate on the principle of implied consent. Patients' rights to consent to or refuse resuscitation or other recommended medical care do not depend on the presence or absence of a terminal illness or the agreement of their physician.

The EMS system, as the extension of medical practice into the field, has the same ethical obligations to honor patient wishes regarding resuscitation. Do not resuscitate directives are a critical part of any EMS system. Patients cannot be refused their legal and ethical rights to consent to or refuse medical care simply because they are in the prehospital setting.

AUTHORITY

Health and Safety Code Section 1797.220 gives local EMS agencies the authority to establish “policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system”, which can include patient care guidelines.

Health and Safety Code Section 1798 states that “the medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency”.

Section 4780 of the Probate Code defines what constitutes a "Request regarding resuscitative measures" or a DNR as well as what forms must be accepted statewide. The EMS Authority is responsible for developing a pre-hospital DNR form and for approving the POLST form.

IMPLEMENTATION PROCEDURES

All local EMS agencies shall have a policy that recognizes and accommodates a patient’s wish to limit prehospital treatment. This should apply to patients in long-term care facilities, during transport between facilities, and in patients' homes. Three instruments are used to assure standard implementation:

- The statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form
- The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) Form
- A standard EMSA approved DNR medallion.

In addition to the three statewide standards mentioned above, the local EMS agency Medical Director may also approve other documents, which may include, but are not limited to the following:

- Physician's order in a patient's chart
- Physician's prescription containing the words Do Not Resuscitate, No CPR, or No Code, that contains the patient's name and is dated and signed by the physician
- Advance Health Care Directives

These other documents may not be honored outside of a particular local EMS agency's jurisdiction. If individuals want to ensure that their wishes are honored consistently throughout California, it is recommended that they utilize one of the standardized instruments mentioned above.

Patients have near-absolute authority to refuse resuscitation. The role of the physician signing the DNR directive should be to evaluate the patient for untreated or inadequately treated illness where additional treatment might change the patient's decision regarding resuscitation.

The physician should ensure that the patient understands the meaning of resuscitation and "do not resuscitate," explain the benefits and risks of a resuscitation attempt, and answer any questions the patient may have. Additionally, the physician should explain the differences in treatment protocols between the statewide EMSA/CMA approved Prehospital DNR, the EMSA approved POLST Form (which includes treatment options for patients admitted to hospitals and other healthcare facilities), and the standard DNR medallion.

The role of the base hospital should be defined. In some cases the base hospital will not be notified and all documentation will appear only on the patient care record. Other jurisdictions may wish to have the base hospital consulted.

In cases where EMS personnel question the validity of the request (e.g. DNR not identified in local DNR policy, conflicting requests by family members, etc.), EMS personnel should be allowed to temporarily disregard the DNR request and institute resuscitation measures while consulting their base hospital for assistance.

If the patient is conscious and states that they wish resuscitative measures, then the DNR Form should be ignored. In rare instances, when the patient is unable to state his or her desire and a family member is present and requests resuscitative measures for the patient, the family member's objection may call into question the validity or applicability of the DNR Form. Although the patient's wishes or instructions should remain paramount, resuscitation may be undertaken until the situation is clarified. Usually discussions with the family will make attempted resuscitation unnecessary.

Clarification may require only discussion with the family member, with explanation, reassurance, and emotional support. Assistance from a base hospital may be helpful. Again, the underlying principle is that the patient's wishes should be respected.

Local EMS agencies should have policies addressing the use of documents other than the EMSA/CMA approved Prehospital DNR Form (see Appendix A) or the EMSA approved POLST form (see Appendix B).

EMS personnel should attach a copy of the approved DNR Form to the patient care record, along with other appropriate written documentation. The DNR Form should accompany the patient so that it may be incorporated into the medical record at the receiving facility. When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician's name. It should be noted on the patient care record that a written DNR order was present including the name of the physician, date signed and other appropriate information.

Patients who are dead at the scene should not be transported by ambulance however; local EMS agencies should consider policies for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital even without resuscitative measures, in order to move the body to a location that provides the family with more privacy and where arrangements can be made more expeditiously. Local policies shall have the approval of the Medical Examiner/Coroner, who has the responsibility for investigating all deaths with other investigative bodies.

EMSA/CMA APPROVED PREHOSPITAL DNR FORM

1. Under the EMSA/CMA approved Prehospital DNR Form, do not resuscitate (DNR) means no chest compressions, defibrillation, endotracheal intubation, assisted ventilation, or cardiotonic drugs.
2. The patient should receive all other care not identified above for all other medical conditions according to local protocols.
3. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
4. Requests must be signed and dated by a physician. No witness to the patient's or surrogate's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.
5. The DNR Form should be clearly posted or maintained near the patient in the home. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transport.
6. In general, EMS personnel should see the written prehospital DNR Form unless the patient's physician is present and issues a DNR order.
7. Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if

documentation is present and the circumstances are consistent. There should be a properly completed standard EMSA/CMA DNR Form available with the patient. A witness who can reliably identify the patient is valuable.

A blank sample EMSA/CMA Prehospital DNR Form is contained in Appendix A.

EMSA APPROVED POLST FORM

EMS personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

Section A

Section A applies only to individuals who do NOT have a pulse and are NOT breathing upon arrival of EMS personnel.

1. If an individual has checked “Attempt Resuscitation/CPR”, then EMS personnel should treat the individual to the fullest extent possible according to local protocols regardless of what may be checked in Section B. For this individual this form as filled out does NOT constitute a DNR.
2. If the individual has checked “Do Not Attempt Resuscitation/DNR”, then no attempts should be made to resuscitate the individual and the EMS personnel should follow their local policies, procedures and protocols for declaration of death.

Section B

Section B applies only to individuals who have checked “Do Not Attempt Resuscitation/DNR” in Section A AND who have a pulse and/or are breathing upon the arrival of EMS personnel.

1. If an individual has checked “Full Treatment” then they should be treated to the fullest extent possible. This includes, but is not limited to, intubation and other advanced airway interventions, mechanical ventilation and defibrillation/cardioversion.

   Should the individual’s condition deteriorate after EMS personnel have arrived and they have indicated “DNR” in Section A, then resuscitation efforts should be attempted up to, but NOT including, chest compressions. Then EMS personnel should follow local protocols regarding declaration of death.

   EMS personnel shall ignore the check box marked “Trial Period of Full Treatment” as it is not applicable to pre-hospital care.
2. If an individual has checked “Selective Treatment” the following care may be provided (in addition to the care outlined below):
   - Administration of IV fluids.

- May use non-invasive positive airway pressure to include: continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations according to local protocols. This does NOT include intubation.
- EMS personnel shall ignore the subjective phrase “avoid burdensome measures” when considering treatment options for the patient. EMS personnel shall follow their local protocols, policies and procedures regarding patient treatments and if necessary contact medical control for further guidance.
- EMS personnel shall ignore the check box marked “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport.

3. If an individual has checked “Comfort-Focused Treatment” the following care may be provided:
    - The patient should receive full palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions (includes medication by any route) according to local protocols.
    - Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
    - EMS personnel shall ignore the statement “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport.
4. EMS personnel shall obtain online medical control prior to following any orders listed under “Additional Orders”.

EMSA approved POLST forms must be signed and dated by a physician and the patient or legally recognized decision-maker. No witness to the patient's or legally recognized decision-maker's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.

The EMSA approved POLST form should be clearly posted or maintained near the patient. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transports.

In general, EMS personnel should see the written EMSA approved POLST form unless the patient's physician is present and issues a DNR order.

Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed EMSA

approved POLST form available with the patient. A witness who can reliably identify the patient is valuable.

A blank sample EMSA approved POLST Form is contained in Appendix B.

DNR MEDALLION

1. The most accurate form of identification for patients outside of licensed facilities is a medallion or bracelet attached to the patient. Use of such a medallion should never make the patient uncomfortable and should always be optional. Every local EMS system should accept an EMSA approved DNR bracelet or medallion.
2. All EMSA approved DNR medallions must include the following information:
   a. 24-hour, seven day a week, telephone number that is toll free to the calling party,
   b. The words, “CALIFORNIA DO NOT RESUSCITATE – EMS”, Or; “CALIFORNIA DNR – EMS”,
   c. An individual specific identification number to be used to identify the enrollee’s medical information on file.

   Medallions should only be issued after receiving a copy of the completed EMSA/CMA approved DNR Request Form or the EMSA approved POLST Form from an individual. Should an individual use a POLST form to acquire their medallion the acronym “POLST” shall be inscribed on the medallion.
3. Should EMS personnel encounter an individual with a DNR medallion, treatment should follow as outlined by the EMSA/CMA approved Prehospital DNR form. If the individual’s medallion indicates “POLST” in addition to “DNR” then if the POLST form is available to the EMS personnel, treatment should follow as indicated on the POLST form. In the absence of a POLST form, when a DNR/POLST medallion is encountered, the EMS personnel should treat the individual in a manner consistent with that outlined by the EMSA/CMA approved DNR until the individual’s valid EMSA approved POLST form is produced.
4. The emergency medical services system must not be used simply to pronounce death in nursing home patients. This inappropriate use of EMS Personnel should be addressed by service providers and/or EMS agencies. DNR orders are aimed at patients who may suffer cardiac arrest during treatment or transfer.
5. Base hospital physicians retain authority for determining the appropriateness of resuscitation. EMS personnel in the field have the ability to contact a base hospital and advise the physician of the details of a particular case if resuscitation appears unwarranted or unwanted by the patient. While field circumstances make this type of ad hoc decision difficult as a routine procedure, it may still apply to specific cases where patients' wishes are known and explicitly expressed.

There are currently two (2) California Approved Medallion Providers. They are the only venders in California that are currently approved to produce Statewide approved prehospital DNR medallions. Their contact information is the following:

- MedicAlert Foundation
  www.medicalert.org
  1-888-633-4298
  2323 Colorado Avenue
  Turlock, CA 95382
- Caring Advocates
  www.caringadvocates.org
  1-800-647-3223
  2730 Argonauta St
  Carlsbad, CA 92009

BACKGROUND MATERIAL ON OTHER ADVANCE DIRECTIVES

These guidelines have focused on the standardized prehospital EMSA/CMA DNR and the EMSA approved POLST form, and physician DNR orders in licensed facilities as the preferred methods for honoring patient decisions to forego cardiac resuscitation. There are several additional written documents or instruments that may be encountered. Local EMS agencies should decide what role, if any, these written instruments play in the prehospital care system. At the very least, emergency responders and base hospital personnel must be aware that these instruments exist and may be presented to the emergency care providers by patients or their families.

There are a variety of "living wills" and advance directives available from many sources. While these may communicate to the rescuer some sense of the patient's wishes regarding resuscitation, the wide variety of these documents and the inability to confirm the legitimacy of the orders makes them unsuitable for emergency use without prior confirmation. A base hospital may, however, elect to use these in guiding a patient's therapy.

Local EMS systems may recognize advance directives. Providers may also be directed to respect the decisions made by an attorney-in-fact at the scene of an emergency when the patient is unable to make decisions for her/himself. Decisions made by the attorney-in-fact should be consistent with any written expressions of the patient’s wishes. Secondly, providers may respect directions they find written in the advance directive regarding withholding or providing resuscitation. Finally, written information in the advance directive gives health care providers direction as to the patient's wishes and may be valuable in assessing whether to proceed with resuscitation.

APPENDICES

APPENDIX A- EMSA/CMA APPROVED PREHOSPITAL DNR FORM

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association

PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel regarding a patient's decision to forego resuscitative measures in the event of cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. This form does **not** affect the provision of life sustaining measures such as artificial nutrition or hydration or the provision of other emergency medical care, such as palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in **prehospital settings** --i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed request regarding resuscitative measures, including a Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion), from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form **must** be signed by the patient or by the patient's legally recognized health care decisionmaker if the patient is unable to make or communicate informed health care decisions. The legally recognized health care decisionmaker should be the patient's legal representative, such as a health care agent as designated in a power of attorney for health care, a court-appointed conservator, or a spouse or other family member if one exists. The patient's physician **must** also sign the form, affirming that the patient/legally recognized health care decisionmaker has given informed consent to the DNR instruction.

The **white copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion—see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **goldenrod** copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The **pink** copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCATION

In the absence of knowledge to the contrary, a health care provider may presume that a request regarding resuscitative measures is valid and unrevoked. Thus, if a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Legally Recognized Health Care Decisionmaker Signature Date

_____
Legally Recognized Health Care Decisionmaker's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

APPENDIX B- EMSA APPROVED POLST FORM

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Cardiopulmonary Resuscitation (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Medical Interventions: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D — Information and Signatures:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Healthcare Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

Healthcare Provider Assisting with Form Preparation ☐ N/A if POLST is completed by signing physician

Name:	Title:	Phone Number:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone Number:

Directions for Healthcare Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

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

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

APPENDIX C – EMSA APPROVED DNR MEDALLIONS

GUIDELINES FOR EMS PERSONNEL REGARDING DO NOT RESUSITATE (DNR) AND OTHER PATIENT-DESIGNATED DIRECTIVES LIMITING PREHOSPITAL CARE

Edmund G. Brown, Jr.
Governor
State of California

Diana S. Dooley
Secretary
Health and Human Services Agency

Howard Backer, MD, MPH, FACEP
Director
Emergency Medical Services Authority

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www.emsa.ca.gov