

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name _____
 First Name/Middle Name _____
 Date of Birth _____ Date Form Completed _____

A **CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse AND is not breathing.*
 Check One Attempt Resuscitation/CPR (Section B: Full Treatment required) Do Not Attempt Resuscitation (DNR/no CPR)
 When not in cardiopulmonary arrest, follow orders in **B, C** and **D**.

B **MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*
 Check One **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort.
 Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. Do not use endotracheal intubation. Additional limitations listed below.
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
Additional Orders: _____

C **TRANSFER TO HOSPITAL:**
 Check One **Transfer** if comfort needs cannot be met in current location.
 Transfer to hospital if indicated. Additional limitations listed in Section B. Avoid intensive care.
 Transfer to hospital if indicated. No limitations. Includes intensive care.

D **ARTIFICIALLY ADMINISTERED NUTRITION:**
 Check One No artificial nutrition by tube. Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
Additional Orders: _____

E **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**
 Discussed with:
 Patient Health Care Decisionmaker Parent of Minor Court Appointed Conservator Other: _____
Signature of Physician
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences.

Print Physician Name	MD/DO Phone Number	Date
Physician signature (required)	MD License #	

Signature of Patient, Parent of Minor, Conservator or Decisionmaker
 By signing this form, the health care decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
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Summary of Medical Condition	Office Use Only
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SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

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

Contact Information

Health Care Decisionmaker	Address	Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number
		Date Prepared

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed

Directions for Health Care Professional**Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- Choosing certain life sustaining treatments may prevent a person from returning to his/her current living situation.

Using POLST

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

Section A:

- No defibrillator (including automated external defibrillators) 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).
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”

Reviewing POLST

It is recommended that POLST should be reviewed periodically and that review be documented above. It should be reviewed if:

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

Modifying or Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw line through Sections A through E and write “VOID in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual’s best interests.

California Coalition for Compassionate Care

The Coalition is the lead agency for implementation of POLST in California. For more information, visit www.finalchoices.org.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED