NEW JERSEY
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your New Jersey Advance Directive

This packet contains a legal document, a **New Jersey Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part I is the **New Jersey Proxy Declaration.** This part lets you name an adult, called your health care representative, or representative, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself.

Part II is a **New Jersey Instruction Declaration**, which is your state's living will. Part II lets you state your wishes regarding health care decisions in the event that you can no longer make your own.

Part III contains the signature and witnessing provisions so that your document will be effective.

Your advance directive goes into effect when your doctor and one other doctor determine in writing that you are no longer able to understand and appreciate the nature and consequences of your health care decisions and you are no longer able to reach an informed health care decision.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions Completing Your Advance Directive for Health care

How do I make my *Advance Directive for Health Care* legal?

You must sign and date your document, or direct another to sign and date it:

1. in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative;

OR

2. before a notary public, an attorney at law, or another person authorized to administer oaths.

Can I add personal instructions to my Living Will?

One of the strongest reasons for naming a representative is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your representative carry out your wishes, but be careful that you do not unintentionally restrict your representative's power to act in your best interest. In any event, be sure to talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life."

Whom should I appoint as my representative?

Your representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as a representative is unable, unwilling, or unavailable to act for you.

You **cannot** appoint an operator, administrator, or employee of your treating health care institution, unless he or she is related to you by blood, marriage, domestic partnership, or adoption. However, you can appoint a physician so long as he or she is not serving as your attending physician at the same time.

What if I change my mind?

You may revoke your Advance Directive, or any part of it, at any time by:

- Announcing your revocation either orally or in writing to your health care representative, your doctor or other health care provider, or a reliable witness,
- Performing any other act that demonstrates your intent to revoke the document, or
- Executing a subsequent Advance Directive.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless you specify otherwise in the "further instructions" section of the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the "further instructions" section of the Advance Directive.

What other important facts should I know?

If you are female, you may include instructions specific to your pregnancy in the event that you are pregnant when your Advance Directive goes into effect.

PART I

PART I: PROXY DIRECTIVE

PRINT YOUR NAME

I, ____, hereby appoint:
(your name)

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR HEALTH CARE REPRESENTATIVE

____
(name of health care representative)

____
(address of health care representative)

____

__________________________ (home phone number)

__________________________ (work phone number)

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.
If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR FIRST ALTERNATE HEALTH CARE REPRESENTATIVE

1. Name ____

Address ____

City ______________________________ State _______________

Telephone ____

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PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SECOND ALTERNATE HEALTH CARE REPRESENTATIVE

2. Name ____

Address ____

City ______________________________ State ________________

Telephone ____

ADD ADDITIONAL INSTRUCTIONS, IF ANY

I direct that my health care representative comply with the following instructions and/or limitations (optional):

____

____

____

____

____

____

(use additional pages if necessary)

ADD INSTRUCTIONS, IF ANY, TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

____

____

____

____

____

(use additional pages if necessary)

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PART II

PART II. INSTRUCTION DIRECTIVE

In Part II, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor and family members or others who may become responsible for your care.

In the sections below, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use the "Further Instructions" section below, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part II before completing your directive.**

General Instructions.
To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care.

Initial ONE of the following two statements with which you agree:

INITIAL ONLY ONE

1. _______I direct that all medically appropriate measures be provided to sustain my life regardless of my physical or mental condition.

2. _______ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

IF YOU INITIAL STATEMENT 2, YOU MUST SPECIFY WHEN YOU WOULD LIKE TO FOREGO LIFE-SUSTAINING MEASURES ON THE FOLLOWING PAGES

If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:

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INITIAL EACH LETTERED STATEMENT (A, B, AND/OR C) THAT REPRESENTS WHEN YOU WOULD LIKE TO FOREGO LIFE-SUSTAINING MEASURES

IF YOU INITIALED STATEMENT A, INDICATE WHAT YOU CONSIDER TO BE A TERMINAL CONDITION THAT WILL JUSTIFY THE WITHHOLDING OR DISCONTINUING OF LIFE-SUSTAINING MEASURES

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a. ______I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and relieve pain. To me, terminal condition means that my physicians have determined that:

______I will die within a few days, or
______I will die within a few weeks, or
______I have a life expectancy of approximately ________or less (enter 6 months or 1 year)

b. _____ If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

c. _____I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater that the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental or physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations, which would provide further guidance to those

IF YOU INITIALED STATEMENT C, ABOVE, YOU MAY LIST CONDITIONS THAT YOU FIND UNACCEPTABLE AND WOULD JUSTIFY THE WITHHOLDING OR DISCONTINUING OF LIFE-SUSTAINING MEASURES

INITIAL YOUR PREFERENCE REGARDING ARTIFICIALLY PROVIDED FLUIDS AND NUTRITION (FOOD AND DRINK)

INITIAL YOUR PREFERENCE REGARDING CPR

YOU MAY ADD FURTHER INSTRUCTIONS REGARDING ARTIFICIALLY PROVIDED FLUIDS AND NUTRITION OR CPR HERE

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who may become responsible for your care. If necessary, you may attach a separate statement to this document or provide your wishes in the "Further Instructions" section, below.)

Examples of conditions that I find unacceptable are:

____
____
____
____
____
____

Specific Instructions: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).

On page 4, above, you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures—artificially provided fluids and nutrition and cardiopulmonary resuscitation.

In the space provided, initial the phrase with which you agree:

1. In the circumstances I initialed on page 4, I also direct that artificially provided fluids and nutrition, such as feeding tube or intravenous infusion,

______be withheld or withdrawn and that I be allowed to die, or

______be provided to the extent medically appropriate.

2. In the circumstances I initialed on page 4, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

______not be provided and that I be allowed to die, or

______be provided to preserve my life, unless medically inappropriate or futile.

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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INITIAL HERE IF YOU HAVE AN OBJECTION TO NEW JERSEY'S BRAIN DEATH DEFINITION

ORGAN DONATION (OPTIONAL)

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES

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BRAIN DEATH:

The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

Initial the following statement only if it applies to you:

____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

ORGAN DONATION (OPTIONAL)

(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues, and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)

_____ I do not want to make an organ or tissue donation and I do not want my representative or family to do so.

OR

_____ Upon my death, I wish to donate:

______ My body for anatomical study if needed.
______ Any needed organs, tissues, or eyes.
______ Only the following organs, tissues, or eyes:

____
____

I authorize the use of my organs, tissues, or eyes:

__________ For transplantation
__________ For therapy
__________ For research
__________ For medical education
__________ For any purpose authorized by law.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

FURTHER INSTRUCTIONS:

____

____

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PART III

USE ALTERNATIVE NO. 1 IF YOU PLAN TO SIGN BEFORE WITNESSES (P. 9)

USE ALTERNATIVE NO. 2 IF YOU PLAN TO HAVE YOUR SIGNATURE NOTARIZED (P. 10)

PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

Signed in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative (use Alternative No. 1 if you plan to sign before witnesses);

OR

Signed before a notary public, an attorney at law, or another person authorized to administer oaths (use Alternative No. 2 if you plan to have your signature notarized).

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SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

Alternative No. 1.

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _________ day of _____________________________ 20______.

Signature ____

Address ____

City ______________________________________ State ________________

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence and he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

YOUR WITNESSES MUST PRINT THEIR NAMES AND ADDRESSES AND SIGN AND DATE HERE

1. Witness ____

Address ____

City ______________________________________ State __________________

Signature ____________________________________ Date _______________

2. Witness ____

Address ____

City ____________________________________ State ____________________

Signature ___________________________________ Date ________________

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SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

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Alternative No. 2.

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _________ day of _____________________________ 20______.

Signature ____

Address ____

City ______________________________________ State ________________

Notary, Attorney at Law, or other person authorized to administer oaths

On ____________________, before me came
(date)

___________________________________,
(name of declarant)

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this ____________ day of _________________, 20 _____.

____
Signature of: (check one)
_____Notary Public
_____ Attorney at Law

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *New Jersey Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your representative and alternate representative, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your representative(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your New Jersey document.

7. Be aware that your New Jersey document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN/PA. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person's Name (last, first, middle) _______________ Date of Birth _______________

Print Person's Address _______________

A	**GOALS OF CARE** *(See reverse for instructions. This section does not constitute a medical order.)*
B	**MEDICAL INTERVENTIONS** *Person is breathing and/or has a pulse* ❒ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status. ❒ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care. ❒ Transfer to hospital for medical interventions. ❒ Transfer to hospital only if comfort needs cannot be met in current location. ❒ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location. **Additional Orders:** _______________
C	**ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION** *Always offer food/fluids by mouth, if feasible and desired* ❑ No artificial nutrition ❑ Long-term artificial nutrition ❑ Defined trial period of artificial nutrition
D	**CARDIOPULMONARY RESUSCITATION (CPR)** *Person has no pulse and/or is not breathing* ❑ Attempt resuscitation/CPR ❑ Do not attempt resuscitation/DNAR Allow Natural Death **AIRWAY MANAGEMENT** *Person is in respiratory distress with a pulse* ❑ Intubate/use artificial ventilation as needed ❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort ❑ Additional Order (for example defined trial period of mechanical ventilation) _______________ _______________
E	If I lose my decision-making capacity, I authorize my surrogate decision-maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN/PA in keeping with my goals: ❑ Yes ❑ No
F	**SIGNATURES** *I have discussed this information with my physician/APN/PA* _______________ Print Name _______________ Signature ❑ Person Named Above ❑ Spouse/Civil Union Partner ❑ Health Care Representative/ Legal Guardian ❑ Parent of Minor ❑ Other Surrogate Has the person named above made an anatomical gift: ❑ Yes ❑ No ❑ Unknown ***These orders are consistent with the person's medical condition, known preferences and best known information.*** _______________ PRINT - Physician/APN/PA Name / Phone Number _______________ Physician/APN/PA Signature (Mandatory) / Date/Time _______________ Professional License Number

SURROGATE INFORMATION

Surrogate listed here is the healthcare representative previously identified in an advance directive: ❑ Yes ❑ No ❑ Unknown

Print Name of Surrogate _______________ Phone Number _______________

Print Surrogate Address _______________

■ **Surrogate listed is only authorized to change this form if "yes" is checked in Section E above.**

SEND ORIGINAL FORM WITH PERSON, WHENEVER TRANSFERRED

DIRECTIONS FOR HEALTHCARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician, advance practice nurse or physician assistant.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- 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 AND VOIDING POLST – *An individual with decision-making capacity can always modify/void a POLST at any time.*

- A surrogate, if authorized in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision-maker, if authorized on this form to do so, may request to modify the orders based on the known desires of the person or, if unknown, the person's best interests.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

Section A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but are not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Activities such as eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis to enable the person to set realistic goals.

Section B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

Section C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

Section D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

Section E

This section is applicable in situations where the person has decision-making capacity when the POLST form is completed. A surrogate may only void or modify an existing POLST form, or execute a new one, if authorized in this section by the person.

Section F

POLST must be signed by a practitioner, meaning a physician, APN or PA, to be valid. Verbal orders are acceptable with follow-up signature by the physician/APN/PA in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.