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

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ____ ____ ____

Last 4 #SSN (optional) ____ ____ ____ ____

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

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

Check One

☐ **Attempt Resuscitation/CPR**

When not in cardiopulmonary arrest, go to part B.

☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
Choosing DNAR will include appropriate comfort measures.

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

Check One

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

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 ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name	Phone Number
	✗ Physician/ARNP/PA-C Signature ***(mandatory)***	Date ***(mandatory)***
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature ***(mandatory)***		Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ 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 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

WASHINGTON

WSMA Washington State Medical Association
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

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Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D Non-Emergency Medical Treatment Preferences

Antibiotics:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

Medically Assisted Nutrition:

Always offer food and liquids by mouth if feasible.

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

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

✗ Physician/ARNP/PA-C Signature	Date
✗ Patient or Legal Surrogate Signature	Date

Directions for Health Care Professionals

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, 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 valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

NOTE: A person with capacity may always consent to or refuse medical care or inverventions, regardless of information represented on any document, including this one.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person 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-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" 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.

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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OVER ▶

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