HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTHCARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND ORIGINAL WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: Portable Medical Orders

Health care professionals should only complete this form after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Note to Patients: Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: ______________________

Middle Name/Initial: ____________ Preferred name: ____________

Last Name: ______________________ Suffix (Jr, Sr, etc): ________

DOB (mm/dd/yyyy): ____/____/______ State where form was completed: __________

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation (requires choosing Full Interventions in Section B)
Use any medically appropriate interventions necessary to sustain life, including mechanical ventilation, defibrillation and cardioversion.

☐ NO CPR: Do Not Attempt Resuscitation (DNR)

B. Treatment Orders: Establishes initial treatment. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative every few days to ensure treatments are meeting patient's care goals. For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.

Pick 1

☐ Full Treatment (required if choose CPR above). Goal: Attempt to sustain life by all medically effective means. Provide all appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function with treatments for reversible medical conditions while avoiding burdensome measures. **Do not intubate**. May use non-invasive positive airway pressure. Use antibiotics and IV fluids as indicated. Avoid intensive care. Request transfer to hospital if treatment needs cannot be met in current location.

Trial Period for Full or Select Interventions (Optional)

☐ < 2 weeks to avoid trach/PEG

OR

☐ Undetermined, possible trach/PEG

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death.
Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Request transfer **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions (e.g., blood products, dialysis). [EMS protocols may limit their ability to act on these orders.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Not discussed or no decision made

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

X (required)	Date:	The most recently completed valid POLST form supersedes all previously completed POLST forms.
If other than patient, print full name:		

F. SIGNATURE: Health Care Provider (eSigned documents are valid)

Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge.
[Note: Only licensed health care professional authorized by law to sign POLST form in state where completed may sign this order]

X (required)	Date (mm/dd/yyyy): Required / /	Phone # : ( )
Printed Full Name:		License/Cert. # :
Supervising physician signature: ☐ N/A		License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive or living will & confirmed no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of document reviewed:____________________ ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate ☐ Other: ____

Health Care Provider Assisting with Form Completion Full Name (if applicable):	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Treating Provider ☐ Social Worker ☐ Other:

Form was completed at: ☐ Home ☐ Primary Care Office ☐ Specialty Clinic ☐ Nursing Facility ☐ Hospital ☐ Other:

Form Information & Instructions

- Completing a POLST form:
  - Provider should document basis for this form in medical record notes.
  - Patient representative is determined by applicable state law and may execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf (verbal orders are acceptable with follow up signature).
  - Original is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- Using POLST form:
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
- Reviewing POLST form: This form does not expire but should be reviewed whenever the patient:
  - (1) is transferred from one care setting or level to another;
  - (2) has a substantial change in health status;
  - (3) changes primary provider; or
  - (4) changes his/her treatment preferences or goals of care.
- Modifying POLST form: This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- Voiding a POLST form:
  - **If a patient or (for patient's lacking capacity, the patient representative) wants to void the form**: destroy form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable).
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- Additional Forms. Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker