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

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. 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.

A  CARDIOPULMONARY RESUSCITATION (CPR):

☐ 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:

☐ 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:

☐ 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 → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available
☐ No Advance Directive

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA) (Physician/NP/PA)
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/NP/PA Name: ____________________________  Physician/NP/PA Phone #: ____________________________  Physician/NP/PA License #: ____________________________  NP Cert. #: ____________________________

Physician/NP/PA 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 individual who is the subject of the form.

Print Name: ____________________________  Relationship: (write self if patient) ____________________________  Signature: (required) ____________________________  Date: ____________________________  Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHenever TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid*
Section A: Modifying and Voiding 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/NP/PA, based on the known desires of the patient or, if unknown, the patient’s best interests.

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

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.