

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

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 Date of Birth Last 4 #SSN (optional)

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:

A

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

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.*

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: PRINT — Physician/ARNP/PA-C Name

Physician/ARNP/PA-C Signature (**mandatory**)

Patient or Legal Surrogate Signature (**mandatory**)

Agency Info/Sticker

Check

When not in cardiopulmonary arrest, go to part B. one

B Check One

Additional Orders: (e.g. dialysis, etc.)

Date (**mandatory**)

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.

Phone Number

Date (**mandatory**)

PRINT — Patient or Legal Surrogate Name

Person has: Health Care Directive (living will)

Durable Power of Attorney for Health Care

Phone Number

Encourage all advance care planning documents to accompany POLST

Revised 8/2017



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

Patient Parent of Minor Guardian with Health Care Authority Spouse/Other as authorized by RCW 7.70.065 Health Care Agent (DPOAHC)



See back of form for non-emergency preferences ►

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: Trial period of medically assisted nutrition by tube.

Always offer food and liquids by mouth if feasible.

(Goal: _____) No medically assisted nutrition by tube.

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

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

SECTIONS A AND B:

- 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.
- 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 **Using POLST** who desires IV fluids should indicate "Selective" or "Full Treatment."

Any incomplete section of POLST implies full treatment for SECTION D: that section.

- Oral fluids and nutrition must always be offered if medically feasible. **This POLST is valid in all care settings including hospitals until replaced by new physician's orders.**

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

This POLST should be reviewed periodically whenever: **previous orders.**

- (1) The person is transferred from one care setting or care **The POLST does not replace an advance directive. An advance directive**

level to another, or **is encouraged for all competent adults regardless of their health status.**

- (2) There is a substantial change in the person's health status, or **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**

- (3) The person's treatment preferences change.

on his/her behalf. When available, all documents should be reviewed

To void this form, draw line through "Physician Orders" and write "VOID" in to ensure consistency, and the forms updated appropriately to resolve any conflicts.

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 ►