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

# Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ____ ____ ____ Last 4 #SSN ___ ___ ___ ___ Gender M F

**FIRST** follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST form is always voluntary. 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. Everyone shall be treated with dignity and respect.

**Medical Conditions/Patient Goals:**

Agency Info/Sticker

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

☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

**Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.**

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

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

*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 4/2014

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 State Medical Association WSMA
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

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## Other Contact Information (Optional)

| Name of Guardian, Surrogate or other Contact Person | Relationship | Phone Number | |
|---|---|---|---|
| Name of Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared |

## D Non-Emergency Medical Treatment Preferences

### Antibiotics:

☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

### 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

- The POLST is usually for persons with serious illness or frailty.
- Completing a POLST form is always voluntary.
- The POLST must be completed by a health care provider based on the patient'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.**

SECTION A:
- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," 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 Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" 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.

**A competent adult, or the surrogate of a person who is not competent, can void the form and request alternative treatment.**

**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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