

<p align="center">Physician Orders for Life-Sustaining Treatment (POLST)</p> <p>This is a Physician Order Sheet. Based on patient/resident wishes and medical indications, it summarizes any Advance Directive. Any section not completed indicates full treatment for that section. When need for resuscitation occurs, first follow these orders, then contact physician. The purpose of Parts B, C, and D are to provide physician orders on end of life care as patients move through the various health care settings. Notify physician of any significant change in medical condition.</p>	Last Name of Patient/Resident
	First Name/Middle Initial of Patient/Resident
	Patient/Resident Date of Birth

Physician Orders for Life-Sustaining Treatment

Part A check one box only	<p>Resuscitation. Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to “Section B, Medical Interventions.”</p> <p align="center"> <input type="radio"/> Resuscitate <input type="radio"/> Do Not Resuscitate (DNR) </p>
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Part B check one box only	<p>Medical Interventions. Includes Emergency Medical Services. Patient/resident has pulse and/or is breathing.</p> <p><input type="checkbox"/> Comfort Measures Only. Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, wound care, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail.</p> <p><input type="checkbox"/> Limited Interventions. All care above and consider oxygen, suction, treatment of airway obstruction (manual only).</p> <p><input type="checkbox"/> Advanced Interventions. All care above and consider oral/nasal airway, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids.</p> <p><input type="checkbox"/> Full Treatment/Resuscitation. All care above plus CPR, intubation and defibrillation.</p> <p><input type="checkbox"/> Other Instructions:</p>
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Part C check one box only	<p>Antibiotics (notify physician of new infection)</p> <p><input type="checkbox"/> No antibiotics except if needed for comfort</p> <p><input type="checkbox"/> No invasive (IM/IV) antibiotics</p> <p><input type="checkbox"/> Full Treatment</p> <p><input type="checkbox"/> Other Instructions:</p>
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Part D check one box only	<p>Artificially Administered Fluids and Nutrition. Oral fluids and nutrition must be offered if medically feasible.</p> <p><input type="checkbox"/> No feeding tube/IV fluids (provide other measures to assure comfort)</p> <p><input type="checkbox"/> No long term feeding tube/IV fluids (provide other measures to assure comfort)</p> <p><input type="checkbox"/> Full Treatment</p> <p><input type="checkbox"/> Other Instructions:</p>
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Part E	<p>Discussed with:</p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Agent of Durable Power of Attorney</p> <p><input type="checkbox"/> Court-appointed Guardian</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Other (Specify)</p>	<p>The Basis for These Orders Is: (circle all that apply)</p> <p><input type="radio"/> Patient’s request <input type="radio"/> Patient’s known preference</p> <p><input type="radio"/> Patient’s best interest <input type="radio"/> Medical futility</p>
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Physician Name (print)	Physician Signature (mandatory)	Phone	Date
Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)		Date	

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED



Patient/Resident Preferences as a Guide for this POLST Form.							
Part F	Significant thought has been given to life-sustaining treatment and patient preferences have been communicated to physician and/or health care provider(s). This document reflects patient treatment preferences. Further information regarding these preferences may be obtained from the following:						
	<input type="checkbox"/> Advance Directive <i>Attach copy</i> <input type="checkbox"/> Court-Appointed Guardian <i>Attach copy of documentation</i> Name of Guardian <input type="checkbox"/> Agent for Durable Power of Attorney for Health Care <i>Attach copy</i> Name of Agent						
	Please review these orders if there is a substantial change in my health status such as: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Close to death</td> <td style="width: 33%;">Improved Condition</td> <td style="width: 33%;">Advanced progressive illness</td> </tr> <tr> <td>Extraordinary suffering</td> <td>Permanent unconsciousness</td> <td></td> </tr> </table>		Close to death	Improved Condition	Advanced progressive illness	Extraordinary suffering	Permanent unconsciousness
Close to death	Improved Condition	Advanced progressive illness					
Extraordinary suffering	Permanent unconsciousness						
Signature of Person Preparing Form	Preparer Name (Print)	Date					

How to Change This Form

This POLST Form should be reviewed periodically and if:

- ✓ The patient/resident is transferred from one care setting or care level to another, or
- ✓ There is substantial change in patient/resident health status, or
- ✓ The patient/resident treatment preference change.

First, review “Patient/Resident Preferences as a guide for this POLST Form” (Section F).

Second, record the review in “Review of this POLST Form.” (Section G).

Finally, if this form is to be voided, draw a line through the “Physician Orders” and/or **write the word “VOID”** in large letters, then sign or initial the form.

After voiding the form, a new form may be completed.

If no new form is completed, full treatment and resuscitation may be provided.

Review of this POLST Form				
Part G	Review Date	Reviewer	Location of Review	Review Outcome
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)				Date

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

