HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name:	Patient First Name:	Patient Middle Name:	Last 4 SSN: ☐☐☐☐
Address: (street / city / state / zip):		Date of Birth: (mm/dd/yyyy) _____ /_____ /_____	Gender: ☐ **M** ☐ **F**

A — CARDIOPULMONARY RESUSCITATION (CPR): *Unresponsive, pulseless, & not breathing.*

Check One

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

If patient is not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *If patient has pulse and is breathing.*

Check One

☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible.*

Check One

☐ Long-term artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ No artificial nutrition by tube.

Additional Orders (e.g., defining the length of a trial period): _____

D — DOCUMENTATION OF DISCUSSION: (REQUIRED) *See reverse side for add'l info.*

Must Fill Out

☐ Patient (If patient lacks capacity, must check a box below)

☐ Health Care Representative (legally appointed by advance directive or court)
☐ Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion- see reverse side)

Representative/Surrogate Name: _____ Relationship: _____

E — PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT

Signature: ***recommended***	This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box: ☐

F — ATTESTATION OF MD / DO / NP / PA (REQUIRED)

Must Print Name, Sign & Date

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*
MD / DO / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for patient named on this form PATIENT'S NAME: _____

The POLST form is **always voluntary** and is usually for persons with serious illness or frailty. POLST records your wishes for medical treatment in your current state of health (states your treatment wishes if something happened tonight). Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. No form, however, can address all the medical treatment decisions that may need to be made. An Advance Directive is recommended for all capable adults and allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself. Consider reviewing your Advance Directive and giving a copy of it to your health care professional.

Contact Information (Optional)

Health Care Representative or Surrogate:	Relationship:	Phone Number:	Address:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:

PA's Supervising Physician:	Phone Number:

Primary Care Professional:

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- An order of CPR in Section A is incompatible with an order for Comfort Measures Only in Section B (will not be accepted in Registry).
- For information on legally appointed health care representatives and their authority, refer to ORS 127.505 - 127.660.
- Should reflect current preferences of persons with serious illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by MD/DO/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at www.or.polst.org.

Oregon POLST Registry Information

Health Care Professionals:

(1) You are ***required*** to send a copy of <u>both</u> sides of this POLST form to the Oregon POLST Registry unless the patient opts out.

(2) The following sections must be completed:
- Patient's full name
- Date of birth
- MD / DO / NP / PA signature
- Date signed

Registry Contact Information:

Phone: 503-418-4083
Fax or eFAX: 503-418-2161
www.orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: CDW-EM
Portland, Or 97239

Patients:
Mailed confirmation packets from Registry may take four weeks for delivery.

MAY PUT REGISTRY ID STICKER HERE:

Updating POLST: A POLST Form only needs to be revised if patient treatment preferences have changed.

This POLST should be reviewed periodically, including when:

- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes haven't changed, the POLST Form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST <u>must</u> be sent to the Registry unless patient has opted-out.

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry (**required** unless patient has opted out).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care at orpolst@ohsu.edu or (503) 494-3965. Information on the Oregon POLST Program is available online at **www.or.polst.org** or at **orpolst@ohsu.edu**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY