

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

The POLST form is **always voluntary** and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. 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. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive 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.

Contact Information

Surrogate (optional):	Relationship:	Phone Number:	Address:
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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.
- Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/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 <http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf>.

Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)

For the Oregon POLST Registry the following must be completed:

- Patient's full name
- Date of birth
- Section A
- MD / DO / NP / PA signature
- Date signed

Send a copy of **both** sides of this POLST form to the Oregon POLST Registry.

FAX or eFAX:
503-418-2161
or
Mail:
Oregon POLST Registry
CDW-EM
3181 SW Sam Jackson Park Rd.
Portland, OR 97239

Date Submitted _____ / _____ / _____

MAY PUT REGISTRY ID STICKER HERE:

Registry Phone: 503-418-4083

*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.

Reviewing POLST

This POLST should be reviewed periodically and if:

- 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, or
- The patient's primary care professional changes.

Voiding POLST

- 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 as above (required).
- 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. Information on the POLST program is available online at www.polst.org or at polst@ohsu.edu.

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