Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/ First/ Middle Initial

Address

City / State / Zip

Date of Birth (mm/dd/yyyy)	Last 4 SSN	Gender
____ / ____ / ______	☐☐☐☐	☐ M ☐ F

A — Check One

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

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

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

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, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

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

☐ **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: ____________________

C — Check One

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if medically indicated.

Additional Orders: ____________________

SAMPLE

D — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

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

Additional Orders: ____________________

E

REASON FOR ORDERS AND SIGNATURES

My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by the **discussion with**:

☐ Patient ☐ Health Care Representative ☐ Parent of Minor

☐ Court-Appointed Guardian ☐ Other ________________

Print Primary Care Professional Name		Office Use Only
Print Signing Physician / NP / PA Name and Phone Number ( )		
Physician / NP / PA Signature (mandatory)	Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Information for Person Named on this Form

This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate

Signature	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate (optional)	Relationship	Phone Number	Address

Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared

PA's Supervising Physician	Phone Number

SAMPLE

Directions for Health Care Professionals

Completing POLST

- Should reflect person's current preferences. Encourage completion of an advance directive.
- POLST must be signed by a physician/NP/PA to be valid. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and FAXes are legal and valid.

Using POLST

Section A:

- No defibrillator (including AEDs) 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).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which prolongs 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.
- A person with capacity, or the surrogate of a person without capacity, can void the form and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and if:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.

The POLST program was developed by the Oregon POLST Task Force and is housed at OHSU's Center for Ethics in Health Care. For permission to use the copyrighted form contact the Center. Information on the POLST program is available online at **www.polst.org** or at **polst@ohsu.edu**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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