

Fax

To: OR POLST REGISTRY: 503-418-2161

Organization Name: _____

Contact Name: _____

Fax: _____

Phone: _____

Date: _____

Pages: _____

REMINDER: REQUIRED ELEMENTS FOR POLST FORM TO BE ENTERED INTO REGISTRY.

- Patient's full name
- Patient's date of birth
- Signature of Physician, NP, or PA (*must have a legible printed name of signer)
- Section A (CPR/no CPR)
- Date form signed

POLST Registry ID Report (OPTIONAL)

Please complete the following information to receive the POLST Registry ID number(s) assigned to the patient/resident orders within this fax. The primary contact person listed below certifies the authority to make this request and the security of the listed fax number to receive protected health information.

Facility/Institution Name: _____

Primary Contact Person: _____

Secure Fax number: _____ **Phone number:** _____ **x** _____

Patient Name	Patient DOB	POLST Registry ID	Date Signed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			