

# Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

|                            |
|----------------------------|
| Last Name                  |
| First Name/ Middle Initial |
| Date of Birth              |

|          |  |
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| <b>A</b> | <p><b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.</b></p> <p><input type="checkbox"/> Resuscitate/CPR                      <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR)</p> <p>When not in cardiopulmonary arrest, follow orders in <b>B, C</b> and <b>D</b>.</p> |
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| <b>B</b> | <p><b>MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.</b></p> <p><input type="checkbox"/> <b>Comfort Measures Only</b> 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. <b>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</b></p> <p><input type="checkbox"/> <b>Limited Additional Interventions</b> Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <b>Transfer to hospital if indicated. Avoid intensive care.</b></p> <p><input type="checkbox"/> <b>Full Treatment</b> Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <b>Transfer to hospital if indicated. Includes intensive care.</b></p> <p>Additional Orders: _____</p> |
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| <b>C</b> | <p><b>ANTIBIOTICS</b></p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs.</p> <p><input type="checkbox"/> Use antibiotics if life can be prolonged.</p> <p>Additional Orders: _____</p> |
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| <b>D</b> | <p><b>ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.</b></p> <p><input type="checkbox"/> No artificial nutrition by tube.</p> <p><input type="checkbox"/> Defined trial period of artificial nutrition by tube.</p> <p><input type="checkbox"/> Long-term artificial nutrition by tube.</p> <p>Additional Orders: _____</p> |
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|  |  |                               |
|--|--|-------------------------------|
| <b>SUMMARY OF MEDICAL CONDITION AND SIGNATURES</b>   |  |                               |
| <p><b>E</b></p> <p><b>Discussed with:</b></p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Health Care Representative</p> <p><input type="checkbox"/> Court-Appointed Guardian</p> <p><input type="checkbox"/> Other: _____</p> | <p><b>Summary of Medical Condition</b></p><br><br><br><br><br> |                               |
| <p><b>Print Physician/ Nurse Practitioner Name</b></p>   | <p><b>MD/DO/NP Phone Number</b></p>                            | <p><b>Office Use Only</b></p> |
| <p><b>Physician/ NP Signature (mandatory)</b></p>  | <p><b>Date</b></p>   |                               |

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

## HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

### Signature of Person, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. (If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

|                      |              |  |
|----------------------|--------------|--|
| Signature (optional) | Name (print) | Relationship (write "self" if patient) |
|----------------------|--------------|--|

### Contact Information

|  |                |              |               |
|--|----------------|--------------|---------------|
| Surrogate (optional)                               | Relationship   | Phone Number |               |
| Health Care Professional Preparing Form (optional) | Preparer Title | Phone Number | Date Prepared |

## Directions for Health Care Professionals

### Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications.

POLST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

### Using POLST

Any incomplete section of POLST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Oral fluids and nutrition must always be offered if medically feasible.

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 Interventions" or "Full Treatment."

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

### Reviewing POLST

This POLST should be reviewed periodically and if:

- (1) The person is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the person's health status, or
- (3) 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 Oregon POLST Task Force

The POLST program was developed by the Oregon POLST Task Force. The POLST program is administratively housed at Oregon Health & Science University's Center for Ethics in Health Care. Research about the safety and effectiveness of the POLST program is available online at <[www.polst.org](http://www.polst.org)> or by contacting the Task Force at <[polst@ohsu.edu](mailto:polst@ohsu.edu)>.

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**