

# Physician Orders

## for Life-Sustaining Treatment (POLST)

This is a Physician Order Sheet. It is based on patient/resident medical condition and wishes. It summarizes any Advance Directive.

ANY SECTION NOT COMPLETED INDICATES FULL TREATMENT FOR THAT SECTION. WHEN THE NEED OCCURS, FIRST FOLLOW THESE ORDERS, THEN CONTACT PHYSICIAN.

Last Name of Patient/ Resident

First Name/ Middle Initial of Patient/ Resident

Patient/ Resident Date of Birth Gender

/ / M F

Clinic #

Clinic

**Section A** Treatment options when the patient/resident is not breathing and has no pulse.

Resuscitate  Do Not attempt or continue any Resuscitation (DNR)

Check One Box Only

**Section B** Treatment options when the Patient/Resident has pulse and/or is breathing.

**Comfort Measures Only.** The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. If comfort measures fail, contact physician. For hospitalization transfer to: \_\_\_\_\_

**Limited Additional Interventions:** Includes care above. May include cardiac monitor and oral/IV medications. Transfer to hospital if indicated, but no endotracheal intubation or long term life support measures. Usually no intensive care.

**Aggressive Treatment:** Includes care above plus endotracheal intubation, advanced airway, and cardioversion/automatic defibrillation.

**Other Instructions:** \_\_\_\_\_

**Section C** Antibiotics

No antibiotics except if needed for comfort (e.g. dental infection)

No Invasive (IM/IV) antibiotics

Aggressive Treatment

**Other Instructions:** \_\_\_\_\_

**Section D** Artificially Administered Fluids and Nutrition Comfort measures are always provided.

No feeding tube/IV fluids

Defined trial period of feeding tube/IV fluids

Long term feeding tube/IV fluids

**Other Instructions:** \_\_\_\_\_

**Section E**

Discussed with:  Patient/Resident  Health Care Agent  Court-appointed Guardian

Other (specify): \_\_\_\_\_

Name of agent/guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

THE BASIS FOR THESE ORDERS IS:

Signature of Physician/Nurse Practitioner (mandatory)

Physician/NP Name (type or print)

Time and Date Signed

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED.