HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name:	Patient First Name	Middle Int.
Date of Birth: (mm/dd/yyyy) ______ ______ ______	Gender: ☐ **M** ☐ **F**	Last 4 SSN: ☐☐☐☐
Address: (street / city / state / zip)		

A — CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse and is not breathing.*

Check One

- ☐ **Attempt Resuscitation/CPR**
- ☐ **Do Not Attempt Resuscitation/DNR**

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

B — MEDICAL INTERVENTIONS: *If patient has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.*
Treatment Plan: Maximize comfort through symptom management.

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: ____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible.*

Check One

- ☐ No artificial nutrition by tube.
- ☐ Long-term artificial nutrition by tube.

Additional Orders: ______________________
____

D — DOCUMENTATION OF DISCUSSION:

- ☐ Patient (Patient has capacity)
- ☐ Parent of minor
- ☐ Court-Appointed Guardian
- ☐ Agent under Health Care Power of Attorney
- ☐ A legally recognized surrogate under A.R.S. §36-3231.

Signature of Patient or Surrogate

Signature: ***required***	Name (print):	Relationship (write "self" if patient):

E — SIGNATURE OF PHYSICIAN / NP / PA

Print Signing Physician / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*
Physician / NP / PA Signature: ***required***	Date: ***required***	

F	**SIGNATURE OF PREPARER**		
	MY SIGNATURE BELOW INDICATES TO THE BEST OF MY KNOWLEDGE THAT THESE ORDERS ARE CONSISTENT WITH THE PATIENT'S **CURRENT** PREFERENCES		
	Preparer Name:	Preparer Phone Number:	Preparer Title: *(optional)*
	Preparer Signature:	Date:	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

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 Arizona 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:

Health Care Professional Information

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 and faxes are also legal and valid.
- Section F does not need to be completed if the Physician/NP/PA is the Preparer.
- If Section F is completed, the name, signature and date of the Preparer are required.

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.
- If included in an electronic medical record, follow voiding procedures of facility/community.

Information on the POLST program is available online at **www.polst.org**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED.