

HIPAA PERMITS DISCLOSURE TO HEALTH PROFESSIONALS INVOLVED IN THE PATIENT'S CARE

Provider Orders for Life-Sustaining Treatment (POLST)

This is a Physician/APRN Order Sheet. First follow these orders, then contact physician or APRN. 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.

Patient Last Name

Patient First Name/Middle Initial

Date of Birth (mm/dd/yyyy)

Gender

Section A
Check One**Cardiopulmonary Resuscitation (CPR): Patient has no pulse and/or is not breathing.**☐ **YES, Attempt CPR**☐ **NO, Do Not Attempt Resuscitation/DNR** Follow orders in B, C and D when not in cardiopulmonary arrest.**This will constitute a DNR order, and no separate DNR Order will be required.****Section B**
Check One**Interventions:**☐ **Full Treatment** – Includes treatment described below, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. **Treatment Plan: Full treatment including life support measures in the intensive care unit.**☐ **Selective Interventions** – Includes treatments described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital level of treatment to meet need, if indicated. Avoid intensive care. **Treatment Plan: Provide basic medical treatments.**☐ **Comfort-focused Care** – Use medication by any route, positioning, wound care, oxygen, and other measures to relieve pain and discomfort. Patient prefers no transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. **Treatment Plan: Maximize comfort through symptom management.***Other Orders (e.g. time limited treatment, hospice evaluation, etc.):***Section C**
Check Only One in Each Column**Medically Administered Fluids and Nutrition.** Oral fluids and nutrition must be offered if medically feasible and consistent with patient's goals of care.☐ IV fluids long-term for hydration and nutrition☐ Feeding tube long-term☐ IV fluids for a defined trial period☐ Feeding tube for a defined trial period☐ No IV Fluids for hydration and nutrition☐ No feeding tube**Section D**
Check One☐ Antibiotics if life prolonging☐ No antibiotics☐ Antibiotics only if likely to contribute to comfort**Section E**
Check All That Apply**The basis for these orders is:**☐ Patient☐ Parent(s) of minor☐ DPOAH agent☐ Surrogate☐ Court-appointed guardian☐ Other (specify): _____**This order has been discussed with the patient named above (or agent, guardian, or parent named below), who has given consent as evidenced by signature below.****Documentation of discussion is located in medical chart at:****Date of Discussion:****Mandatory Signature of Patient or Activated DPOAH, Guardian, Surrogate or Parent of Minor, and Physician/APRN**

Name (Print)	Signature (Mandatory)	Date	Relationship (write "self" if patient)
Physician/APRN Name: (Print)	Physician/APRN Phone Number:	Physician/APRN State License Number:	
Physician/APRN Signature: (Mandatory)		Date: (Mandatory)	