

<p style="text-align: center;"><b>Physician Orders</b> <b>For Life-Sustaining Treatment (POLST)</b></p> <p>This is a Physicians Order Sheet. Based on patient/resident wishes and medical indications, it summarizes any Advanced Directive. Any section not completed indicates full treatment for that section.</p> <p>When need for resuscitation occurs, <u>first</u> follow these orders, <u>then</u> contact physician. The purpose of Parts B, C and D are to provide physicians orders on end of life care as patients move through the various health care settings. <u>Notify physicians of any significant change in medical condition.</u></p>	Last Name of Patient/Resident
	First Name/Middle Initial of Patient/Resident
	Patient/Resident Date of Birth:

**Physicians Orders for Life Sustaining Treatment**

<b>Part A</b> check one box only	<p><b>Resuscitation.</b> Patient/Resident has no pulse and is not breathing.</p> <p style="text-align: center;">For all other medical circumstances, refer to "Section B, Medical Interventions."</p> <p style="text-align: center;"><input type="checkbox"/> Resuscitate                      <input type="checkbox"/> Do Not Resuscitate (DNR)</p>
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<b>Part B</b> check one box only	<p><b>Medical Interventions:</b> Includes Emergency Medical Services.</p> <p style="text-align: center;">Patient/Resident has pulse and/or is breathing.</p> <p><input type="checkbox"/> <b>Comfort Measures Only.</b> Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, wound care, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail.</p> <p><input type="checkbox"/> <b>Limited Interventions.</b> All care above and consider oxygen, suction, treatment of airway obstruction (manual only)</p> <p><input type="checkbox"/> <b>Advanced Interventions.</b> All care above and consider oral/nasal airway, bag-masked/demand valve, monitor cardiac rhythm, medication, and IV fluids.</p> <p><input type="checkbox"/> <b>Full Treatment/Resuscitation.</b> All care above plus CPR, intubation and defibrillation.</p> <p><input type="checkbox"/> <b>Other Instructions:</b></p>
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<b>Part C</b> check only one box	<p><b>Antibiotics (notify physician of new infection)</b></p> <p><input type="checkbox"/> No antibiotics except if needed for comfort</p> <p><input type="checkbox"/> No invasive (IM,IV) antibiotics</p> <p><input type="checkbox"/> Full Treatment</p> <p><input type="checkbox"/> <b>Other Instructions:</b></p>
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<b>Part D</b> check one box only	<p><b>Artificially Administered Fluids and Nutrition.</b> Oral fluids and nutrition must be offered if medically feasible.</p> <p><input type="checkbox"/> No feeding tube/IV fluids (provide other measures to assure comfort)</p> <p><input type="checkbox"/> No long term feeding tube/IV fluids (provide other measures to assure comfort)</p> <p><input type="checkbox"/> Full Treatment</p> <p><input type="checkbox"/> <b>Other Instructions:</b></p>
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<b>Part E</b>	<p><b>Discussed with:</b></p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Agent of Durable Power of Attorney</p> <p><input type="checkbox"/> Court Appointed Guardian</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Other (Specify)</p>	<p><b>The Basis for These Orders Is: (Check all that apply)</b></p> <p><input type="checkbox"/> Patient/Resident Request                      <input type="checkbox"/> Patient/Resident known preference</p> <p><input type="checkbox"/> Patient/Resident's best interest                      <input type="checkbox"/> Medical futility</p>
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Print Physicians Name:	Physician Signature (mandatory)	Phone#	Date
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Patient/Resident or legal Surrogate of Health Care Signature (mandatory)	Date:
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**Patient/Resident Preferences as a Guide for this POLST Form.**

Significant thought has been given to life-sustaining treatment and patient preferences have been communicated to physician and/or health care provider(s). This document reflects patient treatment preferences. Further information regarding these preferences may be obtained from the following:

**Part F**

- Advance Directive (attach copy)
- Court-Appointed Guardian (attach copy of documentation  
Name of Guardian)
- Agent for Durable Power of Attorney for Health Care (attach copy)  
Name of Agent

**Please review these orders if there is a substantial change in my health status such as:**

- |                         |                           |                              |
|-------------------------|---------------------------|------------------------------|
| Close to death          | Improved Condition        | Advanced progressive illness |
| Extraordinary suffering | Permanent unconsciousness |                              |

Signature of Person Preparing Form:

Preparer Name (print)

Date:

**How to Change This Form**

This POLST Form should be reviewed periodically and if:

- √ The patient/resident is transferred from one care setting or care level to another, or
- √ There is substantial change in patient/resident health status, or
- √ The patient/resident treatment preference change.

First, review "Patient/Resident Preferences as a guide for this POLST form" (Section F).

Second, record the review in "Review of this POLST form." (Section G)

Finally, if this form is to be voided, draw a line through the "Physician Orders" and/or Write the word "VOID" in large letters, then sign or initial the form.

After voiding the form, a new form may be completed.

If no new form is completed, full treatment and resuscitation may be provided.

**Review of this POLST Form**

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed

Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)

Date: