



EMSA #111 B  
(Effective 10/1/2014)\*

# Physician Orders for Life-Sustaining Treatment (POLST)

**First follow these orders, then contact physician.**  
A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

<b>A</b> Check One	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>If patient has no pulse and is not breathing.</i> <i>If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>
	<input type="checkbox"/> <b>Attempt Resuscitation/CPR</b> (Selecting CPR in Section A <b>requires</b> selecting Full Treatment in Section B) <input type="checkbox"/> <b>Do Not Attempt Resuscitation/DNR</b> (Allow Natural Death)

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS:</b> <i>If patient is found with a pulse and/or is breathing.</i>
	<input type="checkbox"/> <b>Full Treatment</b> – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> <b>Trial Period of Full Treatment.</b> <input type="checkbox"/> <b>Selective Treatment</b> – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> <b>Request transfer to hospital only if comfort needs cannot be met in current location.</b> <input type="checkbox"/> <b>Comfort-Focused Treatment</b> – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <b>Request transfer to hospital only if comfort needs cannot be met in current location.</b> Additional Orders: _____ _____

<b>C</b> Check One	<b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food by mouth if feasible and desired.</i>
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____

<b>D</b>	<b>INFORMATION AND SIGNATURES:</b>
	<b>Discussed with:</b> <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed →      Healthcare Agent if named in Advance Directive: <input type="checkbox"/> Advance Directive not available    Name: _____ <input type="checkbox"/> No Advance Directive    Phone: _____
	<b>Signature of Physician</b> My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.
	Print Physician Name: _____                                      Physician Phone Number: _____                                      Physician License Number: _____
	Physician Signature: (required) _____                                      Date: _____
	<b>Signature of Patient or Legally Recognized Decisionmaker</b> I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.
	Print Name: _____    Relationship: (write self if patient) _____
	Signature: (required) _____    Date: _____
	Mailing Address (street/city/state/zip): _____                                      Phone Number: _____                                      Office Use Only: _____

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

\*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

# HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

## Patient Information

Name (last, first, middle):	Date of Birth:	Gender: <b>M</b> <b>F</b>
-----------------------------	----------------	---------------------------

## Healthcare Provider Assisting with Form Preparation

N/A if POLST is completed by signing physician

Name:	Title:	Phone Number:
-------	--------	---------------

## Additional Contact

None

Name:	Relationship to Patient:	Phone Number:
-------	--------------------------	---------------

## Directions for Healthcare Provider

### Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

### Using POLST

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

#### Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

#### Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

### Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- 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.

### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).

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