

# Physician Orders for Life-Sustaining Treatment (POLST)

Last Name \_\_\_\_\_  
 First Name/Middle Initial \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's medical condition and wishes.  
 Any section not completed implies full treatment for that section.  
 Everyone shall be treated with dignity and respect.

**A** **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Check One  Attempt Resuscitation/CPR  Do Not Attempt Resuscitation (DNR/no CPR)  
 When not in cardiopulmonary arrest, follow orders in **B, C** and **D**.

**B** **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Check One  **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.**  
 **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**  
 **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**  
 Additional Orders: \_\_\_\_\_  
 \_\_\_\_\_

**C** **ANTIBIOTICS**  
 Check One  No antibiotics. Use other measures to relieve symptoms.  
 Determine use or limitation of antibiotics when infection occurs.  
 Use antibiotics if life can be prolonged.  
 Additional Orders: \_\_\_\_\_  
 \_\_\_\_\_

**D** **ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food by mouth if feasible.  
 Check One  No artificial nutrition by tube.  
 Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.  
 Additional Orders: \_\_\_\_\_  
 \_\_\_\_\_

**E** **SUMMARY OF MEDICAL CONDITION AND SIGNATURES**

Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____	Summary of Medical Condition	
	Print Physician Name	MD/DO Phone Number
Physician Signature (mandatory)	Date	

**Signature of Patient, Parent of Minor, Guardian, or Surrogate**

By signing this form, the surrogate acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write "self" if patient)
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**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY****Patient Name (last, first, middle initial)****Date of Birth****Contact Information**

Surrogate (optional)

Relationship

Phone Number

Health Care Professional Preparing Form (optional)

Preparer Title

Phone Number

Date Prepared

**Directions for Health Care Professional****Completing POLST**

Must be completed by health care professional based on patient preferences and medical indications.

POLST must be signed by a physician and the patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

**Using POLST**

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

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

**Reviewing POLST**

This POLST should be reviewed periodically and if:

- (1) The person is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the person's health status, or
- (3) The person's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.

**California Coalition for Compassionate Care**

The California Coalition for Compassionate Care is the statewide leader for implementation of POLST in California. California health care professionals interested in using POLST are strongly encouraged to use this form. As data becomes available, the California Coalition for Compassionate Care will lead the process of further revisions to the California form. For more information on POLST in California, visit <[www.finalchoices.org](http://www.finalchoices.org)>.

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