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

Oregon POLST™

Portable Orders for Life-Sustaining Treatment*

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name:	Suffix:	Patient First Name:	Patient Middle Name:

Preferred Name:	Date of Birth: (mm/dd/yyyy)	Gender:	MRN (optional)
	_____ /_____ /_____	☐ M ☐ F ☐ X	

Address: (street / city / state zip):

A — Cardiopulmonary Resuscitation (CPR): *Unresponsive, pulseless, & not breathing.*

Check One

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

If patient not in cardiopulmonary arrest, follow orders in **B**.

B — Medical Interventions: *If patient has pulse and is breathing.*

Check One

☐ **Comfort Measures Only**. Provide treatments to 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: Provide treatments for comfort through symptom management.

☐ **Limited Treatment**. 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 Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C — Documentation of Who Was Present For Discussion *See reverse side for add'l info.*

Check All That Apply

☐ Patient
☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion - see reverse side)
☐ Relative or friend (without written appointment)

Discussed with (list all names and relationship): _____

_____

D — Patient or Surrogate Signature

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

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

E — Attestation of MD / DO / NP / PA / ND (REQUIRED)

Must Print Name, Sign & Date

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*

MD / DO / NP / PA / ND Signature: ***required***	Date: ***required***	**"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

*Also known as Physician Orders for Life-Sustaining Treatment

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

Information Regarding POLST

PATIENT'S NAME: _____

The POLST form is:

- **Always voluntary and cannot be required**
- **A medical order for people with a serious illness or frailty**
- An expression of wishes for emergency treatment in one's current state of health (if something happened today)
- A form that can be changed at any time, with a health care professional, to reflect new treatment wishes
- **NOT an advance directive**, which is ALSO recommended (an advance directive is the appropriate legal document to appoint a surrogate/health care decision maker)

Contact Information (Optional)

Emergency Contact:	Relationship:	Phone Number:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			

Directions for Health Care Professionals

Completing Oregon POLST™

- Discussion and attestation should be accompanied by a note in the medical record.
- Any section not completed implies full treatment for that section.
- An order of CPR in Section A is incompatible with an order for Comfort Measures Only in Section B (will not be accepted in Registry).
- Photocopies, faxes, and electronically-signed forms are legal and valid.
- Verbal / phone orders from MD/DO/NP/PA/ND in accordance with facility/community policy can be submitted to the Registry.
- For information on determining the legal decision maker(s) for incapacitated patients, refer to ORS 127.505 - 127.660.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at www.oregonpolst.org.

Oregon POLST Registry Information

Health Care Professionals:

(1) Send a copy of both sides of this POLST form to the Oregon POLST Registry unless the patient opts out.

(2) The following must be completed:
- Patient's full name
- Date of birth
- MD / DO / NP / PA / ND signature
- Date signed

Registry Contact Information:

Toll Free: 1-877-367-7657
Fax or eFAX: 503-418-2161
www.orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: BTE 234
Portland, OR 97239

Patients:

If address is listed on front page, mailed confirmation packets from Registry may take four weeks for delivery.

MAY PUT REGISTRY ID STICKER HERE:

Updating POLST: A POLST Form only needs to be revised if patient treatment preferences have changed.

This POLST should be reviewed periodically, including when:

- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes haven't changed, the POLST Form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient has opted-out.

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- For paper forms, 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 your systems ePOLST voiding procedures.
- Regardless of paper or ePOLST form, send a copy of the voided form to the POLST Registry (required unless patient has opted out).

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

***Also known as Physician Orders for Life-Sustaining Treatment**