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www.polst.org

POLST
physician orders for life-sustaining treatment paradigm

September 27, 2013

Cindy Bruzzese, MPA
Executive Director
Vermont Ethics Network
61 Elm Street
Montpelier, VT 05602

Dear Ms. Bruzzese:

Thank you for the work that you and your Vermont colleagues have done to develop your state POLST Paradigm Program: Clinician Orders for Life Sustaining Treatment (COLST). We appreciate the effort that starting your COLST program has involved.

As you know, the National POLST Paradigm Task Force (NPPTF) was created in 2004 to establish quality standards for POLST programs. The NPPTF endorses states that have proved their programs meet those standards. While the NPPTF avoids frequent revisions of these standards, they are periodically reviewed and updated based on experiences in Endorsed states, quality reviews, and research regarding POLST forms and programs.

Due to increasing criticisms of and attacks on the POLST Paradigm, the NPPTF has decided to distinguish POLST Paradigm Programs from those programs that may use "POLST" or a similar term (POST, MOLST, etc) but which are being implemented in a manner open to certain criticisms. These states, which are significantly down the road in implementing their programs state-wide in such a manner that they are not currently on the pathway to becoming endorsed by the NPPTF, will be clearly identified on the National POLST Paradigm Program map on our website (www.polst.org) as a state with a program not conforming to POLST requirements by being shaded grey. This distinction and the explanation of non-conformance with POLST Paradigm standards are increasingly important as the POLST Paradigm is misunderstood by those who are criticizing it. It is necessary for the NPPTF to take this action and distinguish such programs as not following the national model because they are causing confusion about the POLST Paradigm and, as a result, harming the reputation of states who have worked hard to become endorsed POLST Paradigm Programs, meeting the high quality consensus standards developed by the NPPTF.

Unfortunately, the NPPTF has identified Vermont as a state that needs to be labeled as not adhering to the POLST standards created by the NPPTF because its form does not comply with Endorsement requirements. As was discussed in several Developing State Assistance Committee calls, the Vermont form is complicated and lengthy and includes futility language. It also fails to meet POLST Paradigm form standards. Specific major concerns with the form are:

(1) Section A-3 of the COLST contains language defining or qualifying futility (Section 11 under Form Requirements for Endorsement). The NPPTF does not want futility addressed on a POLST form because it opens the POLST Paradigm Program up to attacks. The POLST Paradigm recognizes that allowing natural death to occur is not the same as killing and it is important that POLST forms do not allow for active euthanasia or physician-assisted suicide or the appearance of allowing such activities.
(2) The form lacks a single section clearly defining level of care options beyond CPR (comfort measures only, limited additional interventions, and full treatment); see Section 7 under Form Requirements for Endorsement. While the NPPTF notes that elements of the "limited additional intervention" option have been spread among Sections B-D, the lack of the obvious option is problematic. Data has shown that these three treatment options (see Section B of the attached Oregon POLST form) have the greatest impact on the level of life-sustaining treatments that are provided (Hickman, JAGS 2010). Further, we are concerned these Sections may lead to potentially conflicting results with Section F. The NPPTF recommends combining the elements covered in the COLST Sections B-D with Section F into a single Section (typically referred to as "Section B" on most POLST Paradigm Programs see attached Oregon POLST form as an example). In short, this lack of a "Section B" creates too much confusion to be honored beyond Vermont and is likely less effective in assuring that patient wishes are honored.
(3) Requirement of multiple signatures by clinician increases likelihood of an invalid COLST form and, therefore, an increase in the likelihood the patient's wishes expressed in the COLST are unable to be honored.
(4) The COLST does not contain language required by the NPPTF that comfort measures are always provided, regardless of level of care chosen (Section 10 under Form Requirements for Endorsement).
(5) Section A-4 is unclear and potentially obstructive; the NPPTF was concerned about the form's validity if this section was not complete.

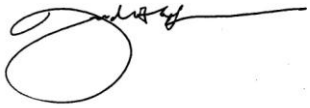
We appreciate the fact that every state faces challenges in working through its unique political situation but the success of the National POLST Paradigm Program is contingent on all POLST Paradigm Programs being unified in their programmatic approach, education of health care providers, and elements of their form. It is only when program quality is uniform that we can achieve credibility, consistency, and reciprocity among all states-- which will ensure that patients will have their wishes honored, wherever they are in the United States at the time of a medical crisis. The COLST, as currently drafted, creates too much confusion to be honored beyond Vermont and is likely less effective in assuring that patient wishes are honored.

We regret having to make this decision. The NPPTF's goal is to encourage and assist all states to achieve endorsement. If you would like to discuss this letter, or the NPPTF's decision, please contact Amy Vandenbroucke at (503) 494-9550 or vandenbr@ohsu.edu. If you would like, she

will also work with the Developing State Assistance Committee to schedule a time for your coalition to meet with them to discuss this letter further.

This change will go into effect on October 31, 2013. If you have any questions or would like additional clarification or assistance, please feel free to contact Amy.

Sincerely,



Judy Citko, JD
Chair, National POLST Paradigm Task Force

Amy Vandenbroucke, JD
Executive Directive, National POLST Paradigm Task Force

Attachments: COLST Form
NPPTF Request for Endorsement Program Status Form
Oregon POLST Form

VERMONT
DEPARTMENT OF HEALTH

INSTRUCTIONS FOR CLINICIANS
COMPLETING VERMONT DNR/COLST FORM
(DO NOT RESUSCITATE ORDER/CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)

Completing DNR/COLST

- The DNR/COLST form must be completed and signed by a health care clinician based on patient preferences and medical indications. A clinician is defined as a medical doctor, osteopathic physician, advance practice registered nurse or physician assistant. 18 V.S.A. § 9701(4). Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/community policy.
- Photocopies and Faxes of signed COLST forms are legal and valid; use of original is encouraged.

Special requirements for completing the DNR section of COLST (18 V.S.A. §9708)

- A DNR order may be written on the basis of either informed consent or futility. Complete section A-2 for informed consent; Section A-3 for futility.
- An order based on informed consent must include the name of the individual giving informed consent.
- An order based on futility must include a certification by the clinician and a second clinician that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.
- If patient is in a health care facility, the clinician must certify that the facility's DNR policy has been followed
- The clinician may authorize the issuance of a DNR identification to the patient
- Clinician must certify that clinician has consulted or made an attempt to consult with the patient, and the patient's agent or guardian.

Using DNR Order - Section A CPR/DNR - 18 V.S.A. § 9708(c)

- A DNR Order (Section A of the DNR/COLST form) only precludes efforts to resuscitate in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient. (Sections B through H of the COLST Form address other interventions.)
- Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR Identification unless the professional or facility believes in good faith, after consultation with the patient, agent or guardian, where possible and appropriate
    - that the patient wishes to have the DNR Order revoked if the Order is based on informed consent, or
    - that the patient with the DNR identification or order is not the individual for whom the DNR order was issued.

  Documentation of basis for belief in medical record is required.

Using COLST (Sections B through H)

- Any section of COLST not completed indicates that the COLST order does not address that topic. It may be addressed in a patient's advance directive, or in other parts of the medical record.
- 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", may be transferred to a setting able to provide comfort.
- Treatment of dehydration is a measure that may prolong life. For a patient who desires IV fluids the order should indicate "Limited Interventions" or Full Treatment."
- A patient with or without capacity, or another person authorized to provide consent, may revoke the COLST order at any time and request alternative treatment. Exceptions may apply. See, 18 V.S.A. § 9707(h) or 18 V.S.A. § 9707(g).
- Photocopies and faxes of signed DNR/COLST forms are legal and valid; use of original is encouraged.

Reviewing DNR/COLST

This form should be reviewed periodically and a new form completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change, or
4. At least annually, but more frequently in residential or inpatient settings.

Voiding DNR/COLST

To void this form or a part of it, draw a line through each page or section to be voided and write "VOID" in large letters.

ATTACHMENT B

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

DNR/COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

FIRST follow these orders, **THEN** contact **Clinician.**

Patient Last Name
Patient First/Middle Initial
Date of Birth

(If patient/resident has no pulse and/or no respirations)

A

DO NOT RESUSCITATE (DNR)

☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)

☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent

Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

_____ _____
Name of Person Giving Informed Consent (Can be Patient) Relationship to Patient (Write "self" if Patient)

_____
Signature (If Available)

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

_____ _____
Name of Other Clinician Making this Determination (Print here) Signature of Other Clinician

Dated:_____

A-4 Facility DNR Protocol (required if applicable)

This patient is ☐ is not ☐ in a health care facility or a residential care facility.

Name of Facility:_____

If this patient is in a health care facility or a residential care facility, the requirements of the facility's DNR protocol have been met._____ (Initial here if protocol requirements have been met.)

A-5 DNR Identification (optional)

I have authorized issuance of a DNR Identification (ID) to this patient. Form of ID:_____

Certification and signature for DNR

A-6 Clinician Certifications and Signature for CPR/DNR (required)

I have consulted, or made an effort to consult with the patient and the patient's agent or guardian.

Patient's Agent or Guardian_____Address or Phone_____

I certify that I am the clinician for the above patient, and I certify that the above statements are true.

_____ _____
Signature of Clinician Printed Name of Clinician

Dated:_____

GIVE COPY TO PATIENT AND REPRESENTATIVE
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT
(If patient/resident is breathing and/or has pulse)

B **INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS:**

If patient has DNR order and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

- ☐ Do Not Intubate/Multi-Lumen Airway (DNI)
- ☐ Trial Period of Intubation/Multi-Lumen Airway and ventilation
- ☐ Intubation/Multi-Lumen Airway and long-term mechanical ventilation if needed

C **TRANSFER TO HOSPITAL**

- ☐ Do not transfer unless comfort care needs cannot be met in current location or if severe symptoms cannot be otherwise controlled
- ☐ Transfer

D **ANTIBIOTICS**

- ☐ No antibiotics. Use other measures to relieve symptoms
- ☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
- ☐ Use antibiotics

E **ARTIFICIALLY ADMINISTERED NUTRITION:** Offer food and liquids by mouth if feasible.

Feeding tube

- ☐ No feeding tube
- ☐ Trial period of feeding tube (Goal:_____)
- ☐ Long-term feeding tube

Parenteral nutrition or hydration (e.g. IV fluids or Total Parenteral Nutrition)

- ☐ No parenteral nutrition or hydration
- ☐ Trial period of parenteral nutrition or hydration (Goal:_____)
- ☐ Long term parenteral nutrition or hydration

F **MEDICAL INTERVENTIONS:**

- ☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Offer food and fluids by mouth, if feasible.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatments and IV fluids as indicated. *Avoid intensive care if possible.*
- ☐ **FULL TREATMENT** Includes care described above. Use defibrillation and intensive care as indicated.

G **Other Instructions**

_____
_____
_____

GIVE COPY TO PATIENT AND REPRESENTATIVE
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

H **Informed Consent and Clinician Signature for COLST Order (Sections B through G)**

Informed Consent for this COLST Order has been obtained from:

_____ _____

Name of Person Giving Informed Consent (Patient if competent) | Relationship to Patient (Write "self" if Patient)

_____

Signature

Clinician Signature for COLST

_____ _____

Signature of Clinician | Printed Name of Clinician

Dated:_____

Print Clinician Name	Clinician Signature (mandatory)	Phone Number
Person providing consent's signature (if available)		Date

Other Contact Information (Optional)

Name of Guardian, Agent or other Contact Person	Relationship	Phone Number

Name of Health Care Professional Preparing Form	Preparer Title/Facility	Phone Number	Date Prepared

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New form completed ☐ Form Voided
			☐ No Change ☐ New form completed ☐ Form Voided
			☐ No Change ☐ New form completed ☐ Form Voided

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
GIVE COPY TO PATIENT AND REPRESENTATIVE

POLST
physician orders for life-sustaining treatment paradigm®

Request for Endorsement Program Status

Endorsed Program Request for:	***Insert State Name Here***

Name:
Title:
Phone:
Fax:
E-mail:

Mail Address:

Check whether the contact information for your state on www.polst.org needs to be updated and notify the national POLST Paradigm office if it does.

Date Completed:
Program Name:
Area of Use:
Program Website:

Date Updated:

The National POLST Paradigm Task Force (NPPTF) strongly encourages POLST Paradigm Programs to develop on a statewide basis. While it recognizes barriers to statewide implementation may exist within individual states and will accept the application of a regional program within a state or within bordering states, the expectation is that an Endorsed Regional POLST Paradigm program will work toward statewide implementation.

Program Status Requested:

☐ Endorsed Regional POLST Paradigm Program
☐ Endorsed Statewide POLST Paradigm Program

Evaluation for Endorsed Programs

Yes	No	Please indicate whether your state or regional program meets each program requirement below (Y/N) and provide evidence of the same.
		1. Has an effective statewide or regional coalition(s). If there are two or more regional coalitions within a state, confirm they are working on a coordinated strategy towards statewide implementation.
		2. Has identified champions who are active in the program implementation and education. Please attach a list of coalition members.
		3. There is an entity within the region or state that is willing to accept ownership for the program (e.g., hospital association, state dept of health, hospice and palliative care association, university-affiliated ethics center, etc) and has the resources to implement it. **Please identify entity**:_____
		4. The POLST Paradigm Program is the preferred practice for appropriate populations (see 6B) for the process of advance care planning and the implementation of that planning across health care settings (e.g., emergency medical services, long-term care, hospital, and hospice). The completion of a POLST Paradigm form should be based on the patient's preferences that are translated into medical orders. The POLST Paradigm system should ensure that the patient receives the treatment that is ordered.
		5. There is ongoing training of health care professionals across the continuum of care about the goals of the program, the creation and use of the form, and how to conduct a POLST Paradigm conversation to elicit and record patients' preferences

		as orders on a POLST Paradigm form. **Please provide copies of sample training materials such as PowerPoint documents, brochures and/or guidelines.**
		6. Program promotes the concepts listed in 6A-B below. 6A. Completion of the form and the decisions recorded on it should be voluntary and based on shared medical decision-making.
		6B. The intended audience for use of POLST Paradigm forms is patients for whom the health care professional's response to the surprise question- "Would I be surprised if this patient died in the next 12 months?"- is "No, I would not be surprised." These include: (1) seriously ill patients with life-limiting progressive advanced illness; and (2) patients with advanced frailty.
		7. The program shows evidence of consideration of the NPPTF document, "Seven Core Elements of Sustainability for State POLST Paradigm Programs" found on www.polst.org.
		8. There is a plan for an ongoing quality evaluation of the program and its implementation. The program has or is in the process of identifying and building a research and quality assurance component. Please see www.polst.org for the POLST Quality and Research Toolkit (PQRsT) for suggestions. It is crucial for each program to be able to receive feedback with regard to how it is functioning.
Yes	**No**	**The following POLST Paradigm Program element is strongly recommended by the NPPTF for Endorsed Programs. Please indicate (Y/N) if your program meets the following program element.**
		9. States accept POLST Paradigm forms completed in other states (reciprocity).
Form Information		
Yes	**No**	**Endorsed Program POLST Paradigm Forms are required to include the following elements. Please indicate whether your state or regional program meets each form requirement below (Y/N).**
		1. The form clearly states that it is a "medical order".
		2. Patient identifying information (e.g., name) is on all pages of the form.
		3. The form is not an advance directive and shall not be combined with an advance directive such as a living will or health care power of attorney document. Since the form is a medical order, there shall not be a requirement that it needs to be witnessed or notarized.
		4. The form requires a valid health care professional signature (physician, nurse practitioner, or physician assistant, depending upon state laws and regulations about who may sign the form) and date of signature. It is a regulatory standard that all medical orders indicate the date issued. The date will allow identification of the most current order.
		5. The form indicates with whom the order was discussed, the patient (if he/she has decision-making capacity) or the patient's surrogate (as identified by state law). Unless there is restrictive language in the state's law, the surrogate has the authority to complete an original or revised POLST Paradigm form for a patient lacking decision-making capacity.
		6. The form provides explicit direction about resuscitation (CPR) instructions or patient preferences if the patient is pulseless and apneic.
		7. In addition to orders with regard to CPR, the form indicates the level of medical intervention for the patient (exact wording for each level may vary from state to state) comfort measures; limited additional interventions; or full interventions.

		Each level of intervention shall contain a description of the services to be provided and the site in which they will be provided (see 7A-C).
		7A. "Comfort Measures". Clearly provides option for "comfort measures" as the focus of treatment. Must provide instruction indicating that the patient is to be transferred if comfort needs cannot be met in the patient's current setting. [Goal is to include language affirming a patient's right to be transferred to receive comfort care.]
		7B. "Limited Additional Interventions". Clearly provides a separate option for "limited additional interventions." This option includes measures for comfort as well as hospital admission and treatment with IV fluids, antibiotics, and cardiac monitoring as appropriate. This option does not include intubation, advanced airway interventions, or mechanical ventilation. It may include less invasive airway support (e.g. CPAP, BiPAP) depending on patient's preferences. Should include a statement "Avoid intensive care" or "Generally avoid intensive care."
		7C. "Full Interventions." The form clearly provides an option for "full interventions". Option includes treatments such as intubation and mechanical ventilation in an intensive care unit. Patients who are already receiving long-term mechanical ventilation may indicate treatment limitations in the "Other Orders" space in the level of medical intervention section.
		8. In section with orders for level of medical intervention, form must provide space for "Additional Orders."
		9. Form clearly states that food and fluids must be offered as tolerated.
		10. Form clearly states that comfort measures are always provided, regardless of level of care chosen.
		11. The form does NOT contain any of the following language: A. "Do not transfer the patient" B. "Avoid calling 911" or "Do not call 911" C. Any language that could be interpreted as restricting or negating a patient's right to access comfort care. D. Language defining or qualifying "futility".
Yes	**No**	**The NPPTF <u>strongly recommends</u> the following POLST Paradigm Form elements to be in the POLST Paradigm Form. Endorsed Programs must show evidence of complying with the majority of these elements. Please indicate whether your state or regional program meets the following recommendations below (Y/N).**
		12. The form is uniquely identifiable (e.g., unique color) and standardized within a state/region. The form indicates on the front page (ideally all pages) the name of the state or region.
		13. Language should be positive and easily understood. [For example, the comfort measures description might read "Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route…" and should avoid negative language suggesting that care and/or comfort of the patient are being denied, "Do not intubate or transport…"]
		14. The original form need not be present at the time of emergency. Form should explicitly state that faxed, copied or electronic versions of the form are legal and valid.
		15. The form also includes directions on other types of intervention that the patient may or may not want. For example, medically administered nutrition, etc.
		16. The form should NOT contain of the following language: Form is rescinded during surgeries, invasive procedures and/or hospital stays.

		[POLST is primarily for out-of-hospital and transition-of-care settings such as the Emergency Department. POLST orders are used to guide hospital admission orders.]
		17. Additions to forms are not prohibited, but language added to the POLST Paradigm form that undermines the goals of the POLST Paradigm Program or the intent of the form may render the program ineligible for endorsement.
		18. All medical orders should be on the first page of the form.
		19. As allowed by statute and regulations, POLST forms should require the patient's (or the patient's surrogate): (a) signature; (b) attestation (if electronic); or (c) witnessed verbal consent. Requiring one of these items provides evidence that the patient or his/her surrogate have reviewed the form, agree with the orders on the form, and that the orders accurately convey their preferences. To increase accountability, it is especially important that programs being established without a governing state statute or regulation develop a process for POLST Paradigm form completion that documents review and approval of the form by the patient or the patient's surrogate has occurred.
		20. Forms should have the following language included on them: "HIPAA permits disclosure to health care professionals as necessary for treatment."
		21. The forms should provide information on how to obtain additional forms.
		22. The forms should provide directions and have specific sections for: (a) completing the form; (b) using the form; (c) updating the form; (d) revoking or voiding the form; and (e) submission to the Registry (if applicable). Directions on revocation or voiding the form should be kept separate for easy navigation.
		23. There should be a section next to the date of the health care professional's signature for the time of completion. The time of the completion of the form should be entered in addition to the date to comply with good practice and regulations in most health care settings.

Program Information

EXTENT OF USE OF POLST PARADIGM FORMS:

Start year:

Used in the following health care settings:

Range of use:

Use by those under 18yrs:

Are you distributing forms: YES ☐ NO ☐ **If yes, how many forms distributed per year:**

HISTORY:

BARRIERS OVERCOME:

RELEVANT STATE LAW AND REGULATIONS:

Describe how your program meets the seven core requirements for sustainability of a POLST Paradigm program (see attachment of the seven core requirements).

POLST PARADIGM IN THE HEALTH CARE SETTING:

Do you have a sample of policies regarding the use of your POLST Paradigm form in health care settings (hospitals, nursing homes, EMS, etc.): YES ☐ NO ☐ (If yes, please attach sample policies)

Do you have a Registry for POLST Paradigm Forms: YES ☐ NO ☐

If no, do you have plans for starting Registry for POLST Paradigm Forms: YES ☐ NO ☐
If yes, please elaborate on the plans (funding, timeline, etc):

POLST PARADIGM PROGRAM MANAGEMENT (please describe):

Describe program management:

Who distributes forms:

Describe how oversight of the program exercised to ensure quality:

POLST PARADIGM TRAINING (please describe):

Training for health care professionals:

Training for the public and patients:

POLST PARADIGM PROGRAM EVALUATION (please describe):

CQI projects and research:

FORM REVIEW (please provide copy of POLST Paradigm Form and describe):

How often, by whom, and under what circumstances is your POLST Paradigm form reviewed?

ADDITIONAL INFORMATION:

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

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. 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. With significant change of condition new orders may need to be written.
For more information on Oregon POLST visit: www.orpolst.org

Patient Last Name:	Patient First Name	Middle Int.

Date of Birth: (mm/dd/yyyy)	Gender:	Last 4 SSN:
_____ _____ _____	☐ **M** ☐ **F**	☐☐☐☐

Address: (street / city / state / zip)

A — CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse and is not breathing.*

Check One

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

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *If patient has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** (**A**llow **N**atural **D**eath). 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: Maximize comfort through symptom management.

☐ **Limited Additional Interventions** 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 Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *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: _____
_____
_____

D — DOCUMENTATION OF DISCUSSION:

☐ Patient (Patient has capacity)
☐ Parent of minor
☐ Court-Appointed Guardian
☐ Health Care Representative or legally recognized surrogate
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
☐ Other _____

Signature of Patient or Surrogate

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 — SIGNATURE OF PHYSICIAN / NP/ PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

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

Physician / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

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

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

Information for patient named on this form PATIENT'S NAME: _____

The POLST form is **always voluntary** and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.

Contact Information

Surrogate (optional):	Relationship:	Phone Number:	Address:

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 POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- 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.orpolst.org.

Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)

For the Oregon POLST Registry the following must be completed:

- Patient's full name
- Date of birth
- Section A
- MD / DO / NP / PA signature
- Date signed

Send a copy of <u>both</u> sides of this POLST form to the Oregon POLST Registry.

<u>FAX or eFAX</u>:
503- 418-2161
or
<u>Mail</u>:
Oregon POLST Registry
CDW-EM
3181 SW Sam Jackson Park Rd.
Portland, OR 97239

Date Submitted _____ /_____ /_____

MAY PUT REGISTRY ID STICKER HERE:

<u>Registry Phone</u>: 503-418-4083
*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.

Reviewing POLST

This POLST should be reviewed periodically and if:

- 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, or
- The patient's primary care professional changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

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

