This is the National POLST Model Form and can only be completed in states that have adopted it. Check with your POLST Program (www.polst.org/map) to determine if your state uses this version.

National POLST Model Form

The National POLST Model Form is a portable medical order. Health care professionals should complete this form only after a conversation with their patient or the patient’s representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

This form should be obtained from a health care provider. It should not be provided to patients or individuals to complete.

Printing the National POLST Model Form

1. Do not alter this form.

2. This national model form must be adopted by the state before it can be completed in that state as a valid POLST form. Find your POLST Program contact at www.polst.org/map – this is because some states have added information on page 2, have added a border, or have requirements about the color of the form.

3. Print BOTH pages as a double-sided form on a single sheet of paper.

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**National POLST Model Form: A Portable Medical Order**

Health care providers should complete this form only after a conversation with their patient or the patient’s representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

### Patient Information

<table>
<thead>
<tr>
<th>Patient First Name:</th>
<th>Middle Name/Initial:</th>
<th>Last Name:</th>
<th>DOB (mm/dd/yyyy):</th>
<th>State where form was completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender: M</th>
<th>F</th>
<th>X</th>
<th>Social Security Number’s last 4 digits (optional): xxx-xx-___ ___ __</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

- **Yes CPR:** Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

- **No CPR:** Do Not Attempt Resuscitation. (May choose any option in Section B)

### B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient’s care goals. Consider a time-trial of interventions based on goals and specific outcomes.

- **Full Treatments** (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

- **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

- **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current location.

### C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).

[EMS protocols may limit emergency responder ability to act on orders in this section.]

### D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

- Provide feeding through new or existing surgically-placed tubes
- Trial period for artificial nutrition but no surgically-placed tubes
- No artificial means of nutrition desired
- Not discussed or no decision made (provide standard of care)

### E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient’s representative, the treatments are consistent with the patient’s known wishes and in their best interest.

- **(required)**
- Authority:

If other than patient, print full name: ____________

### F. SIGNATURE: Health Care Provider (eSigned documents are valid)

Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient’s known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

- **(required)**
- Date (mm/dd/yyyy): Required
- Phone #: __________________________
- License/Cert. #: ____________________
- License #: ________________________

Printed Full Name: ____________________________

Supervising physician signature: □ N/A

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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT WHENEVER TRANSFERRED OR DISCHARGED

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire.

2019
Completing a POLST form

As permitted by law, this form provider should document basis for this form in last 4 digits of SSN are optional but can help identify / match a additional forms patient representative is determined by applicable state law and modifying only licensed health care providers authorized to sign POLST forms in their state if a patient or any incomplete reviewing for health care providers no defibrillator (including automated external defibrillators original if a translated POLST form is used for all options, use medication by any appropriate route, positioning, wound care and other measures to voiding a POLST form

• Completing a POLST form:
  - Provider should document basis for this form in the patient’s medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.

• Using a POLST form:
  - Any incomplete section of POLST creates no presumption about patient’s preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if “No CPR” is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.

• Reviewing a POLST form: This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.

• Modifying a POLST form: This form cannot be modified. If changes are needed, void form and complete a new POLST form.

• Voiding a POLST form:
  - If a patient or patient representative (for patients lacking capacity) wants to void the form: destroy paper form and contact patient’s health care provider to void orders in patient’s medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - For health care providers: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).

• Additional Forms. Can be obtained by going to www.polst.org/form as permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

For more information, visit www.polst.org

Copied, faxed or electronic versions of this form are legal and valid. 2019