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The National POLST model form was developed between 2017 and 2019 through funding from the Gordon and Betty Moore Foundation. The intent was to take the excellent information from the development and adoption of POLST by our state POLST programs, and from experts in the field of serious illness care to develop best practice standards for POLST documentation. This model form and the research supporting it serve as a foundation for our continuing work improving care for the seriously ill.
This POLST Guidance is a resource designed to help health care professionals (physicians, advanced practice professionals, nurses, social workers and/or clergy) engage with individuals, their families, and their legal medical decision makers, to conduct a shared decision-making conversation and complete a POLST document meaningfully and effectively. It also provides details about treatment options to aid in care planning when treating a patient who presents with a valid POLST. We suggest you review this guide with a printed National POLST model form, which can be found on the last page of this guide.

POLST Overview

POLST is a set of portable medical orders designed to communicate an individual’s treatment wishes about the level of medical treatment they want to receive and about emergency care when the individual is unable to speak for themselves. POLST is voluntary, portable, and actionable. Advance directives or Advance care plans differ from POLST. They must be completed when the patient has decision-making capacity but are usually put in effect only when a patient has lost decision-making capacity. Advance directives or advance care plans are legal documents, but they do not carry the force of a medical order. POLST, as a medical order set, is in effect immediately once it is completed and signed. Options selected on the POLST document should be reviewed by the provider and patient (or their decision maker) whenever a patient’s condition changes, when the setting they are being cared for changes, or at least annually.

POLST and Current Law

The POLST process and document originated in the late 1990s in Oregon. Oregon generously supported the start of a national organization to share this work. The use of POLST spread through information sharing across states via the National POLST Paradigm, the early name of the National POLST Collaborative.

It is critical to recognize that states have the responsibility for law and regulation governing end-of-life care. This means that each state should incorporate the evidence-based best practices developed through the work of the National POLST Collaborative, balanced with and considering specific state legislation and regulations. In nearly all states, a state POLST organization led by local experts and users has developed. They look at the best practices and their state regulation and recommend to clinicians in their state how to best implement and use POLST to improve care for patients facing serious, progressive illness or frailty due to aging. Additionally, the National POLST Collaborative has consultative expertise available to help state programs.

Intended Population

POLST is intended for individuals with a serious or chronic, progressive illness, or advanced frailty due to aging. Examples of medical conditions in which a POLST should be considered include:

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
• Advanced Renal Disease
• Advanced Liver Disease
• Advanced Frailty
• Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson’s Disease, ALS)

More information can be found at this link on the National POLST Collaborative website: polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf

Here is a summary of the difference in use of advance directives and POLST

<table>
<thead>
<tr>
<th>ADVANCE DIRECTIVE</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO?</strong></td>
<td></td>
</tr>
<tr>
<td>Every Adult</td>
<td>Life-limiting illness regardless of age; frailty due to aging</td>
</tr>
<tr>
<td><strong>WHAT?</strong></td>
<td></td>
</tr>
<tr>
<td>Broad outline naming an agent, but requiring interpretation and translation to a medical order to be actionable</td>
<td>Specific, actionable medical orders</td>
</tr>
<tr>
<td><strong>WHERE?</strong></td>
<td></td>
</tr>
<tr>
<td>Needs to be provided by patient; no universal system</td>
<td>Travels with patient across health care settings</td>
</tr>
</tbody>
</table>

**Completing a POLST: Section by Section**

The front side of the POLST document contains the medical orders. The reverse side contains patient contact information and a description of how to use and void the document.

This guide will review key elements of each section of the POLST by category:

• Patient Information
• Section A. Cardiopulmonary Resuscitation Orders
• Section B. Initial Treatment Orders
• Section C. Additional Orders or Instructions
• Section D. Medically Assisted Nutrition
• Section E. Patient or Patient Representative Signature
• Section F. Health Care Provider Signature
• Additional Contact Information
• Form Completion Details
• General Form Instructions

Step 1: Patient Information

It is important to complete this section as patient-identifying information helps ensure correct identification of the individual.

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Having a POLST form is always voluntary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: <a href="http://www.polst.org/form">www.polst.org/form</a></td>
<td></td>
</tr>
</tbody>
</table>

Patient First Name: ____________________________
Middle Name/Initial: ____________________________ Preferred name: ____________________________
Last Name: ____________________________ Suffix (Sr, etc.): ____________________________
DOB (mm/dd/yyyy): ___/___/______ State where form was completed: ____________________________
Gender: □ M  □ F  □ X Social Security Number’s last 4 digits (optional): xxx-xx- ___ ___ ___

Step 2: Level of Care and Treatment Decisions

• Starting with Section B Initial Treatment Orders may build rapport for exploring difficult decisions by first exploring scenarios in which the individual has a pulse and/or is breathing. Section B translates the individual’s goals of care into a level of care preference. Completing Section B first can help inform guidance on the CPR decision in Section A.

• Guide the individual in understanding the implications of their decisions within the context of their medical condition and prognosis.
**Section B: Initial Treatment Orders**

**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.

<table>
<thead>
<tr>
<th>Pick 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Full Treatments (required if choose CPR in Section A). <strong>Goal:</strong> 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.</td>
</tr>
<tr>
<td>☐ Selective Treatments. <strong>Goal:</strong> 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.</td>
</tr>
<tr>
<td>☐ Comfort-focused Treatments. <strong>Goal:</strong> 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 setting.</td>
</tr>
</tbody>
</table>

### Treatment Preferences and Location of Care

<table>
<thead>
<tr>
<th>Goals</th>
<th>Longevity</th>
<th>Maintain Current Function / Level of Independence</th>
<th>Quality of Life / Relief of Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location of Care</strong></td>
<td>Hospital + ICU</td>
<td>Hospital, Basic Care</td>
<td>Stay at home, Hospice</td>
</tr>
<tr>
<td><strong>Treatment Level (Section B)</strong></td>
<td>Full Treatment</td>
<td>Selective Treatment</td>
<td>Comfort-focused Treatment</td>
</tr>
</tbody>
</table>
| **Preferences** | • Use all means to maintain life.  
• OK with invasive, aggressive measures.  
• Discuss time-trials. | • Treat treatable conditions.  
• Discuss all reasonable measures, including surgery. | • Arrange care at home.  
• Planning for end of life.  
• Transfer only if comfort not possible. |

*Here are a few concepts to consider discussing with the patient about the treatment levels:*

- **“Full Treatments” includes being in the ICU, potentially having a breathing tube, and being on a ventilator.**
- **Time-limits are an important concept.**
  - A statement such as, “Agree to prolong life with machines to allow time for family to arrive.” Is one example of this. If the patient has a specific duration in mind, it can be documented in Section C: Additional Orders
  - Another example might be “intubation ok up to 2 weeks, only if improvement is clear, otherwise transition to Comfort-Focused Interventions”.
- **Explaining what Comfort-Focused Treatments means is also beneficial.**
It does not mean no care—rather it means doing things that keep the patient comfortable, typically at home if that is feasible and desired. Keep in mind that some patient may wish to be at the hospital.

Comfort-focused treatments can include medications to manage pain and shortness of breath, ice, or other moisteners to deal with dry mouth, and other palliative interventions.

- Talking about what might occur that would justify a trip to the hospital to regain comfort, if anything, such as a painful infection or a fracture requiring surgical intervention can be helpful.

Section C: Additional Orders or Instructions

Sometimes, based on the discussion, additional orders or instructions may be applicable. This can be a space to provide details about agreed-upon time trials of Nutrition/Hydration, and/or dialysis, as examples.

| 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.] |

Step 3: Cardiopulmonary Resuscitation Decision

- **Match Resuscitation choices in Section A to the range of treatment options selected in Section B.**

- **Guide the individual in understanding the implications of having CPR in the context of their medical condition. Address how the decisions made for Section B: Initial Treatment Orders, affect resuscitation choices. Use their goal and the decision in Section B as a basis for making a recommendation about whether to attempt CPR.**

Section A: Cardiopulmonary Resuscitation Orders

| A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing. |
| Pick 1 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) |

- Make sure the person understands that the request to perform or withhold CPR **ONLY** applies when their heart has stopped beating and they are not breathing—in other words, they are clinically dead. An order for DNR does not mean “do nothing” or “just let me die” under any situation where their heart is still beating or they are still breathing. In those instances, healthcare professionals will do what is indicated in Section B.

- **If an individual chooses “Full Treatments” in Section B:**

  - Use shared decision-making to discuss the expected outcomes of CPR, given their medical condition. Realize that “Full Treatments” can be matched with “YES CPR” or “NO CPR”.
• **NOTE:** Choosing “Yes CPR” in Section A requires the selection of “Full Treatments” in Section B.

• If an individual chooses “Selective Treatments” or “Comfort-Focused Treatments” in Section B:
  - Discuss how their Section B decision is inconsistent with having CPR.
  - Make medical recommendation: “NO CPR: Do Not Attempt Resuscitation” is indicated for these treatment preferences.

• If the patient’s heart stops while hospitalized, the in-hospital orders may vary from POLST as hospital-based care can offer more immediate intervention and support. The POLST should be honored during admission to a hospital, but the admitting process should include a review of the individual's goals in the context of their current medical condition, including any new risks they may be facing.
  - Sometimes, a new POLST is appropriate; this means voiding the previous document, done by writing VOID in large print across the front of the document and completing a new POLST. It is the responsibility of the clinician to ensure that the electronic medical record contains this newer POLST document. [In electronic medical records systems, please refer to their instructions for voiding documents]

**Step 4: Choices about Medically Assisted Nutrition**

• This section is about preferences for medically assisted nutrition, otherwise known as artificial feeding or nutrition or tube feeding. Options are most often discussed in the context of other medical care, not during the delivery of emergency care. Patients may also have known wishes in their advance directives about medically assisted nutrition if they are no longer able to make their own decisions. As part of this conversation, review of advance directives to ensure consistency is highly recommended.

• Medically assisted nutrition has not been shown to prolong life in moderate to late-stage dementia, and it is associated with complications.

• If a trial period is the choice selected, and the patient has a specific duration limit in mind, place the time duration of the trial in Section C: Additional Orders or Instructions.

**Section D: Medically Assisted Nutrition**

| D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated) |
|---------------------------------|--------------------------------------------------|
| Pick 1 | Provide feeding through new or existing surgically-placed tubes | No artificial means of nutrition desired |
|       | Trial period for artificial nutrition but no surgically-placed tubes | Not discussed or no decision made (provide standard of care) |

**Step 5: Signatures**

• Signatures are part of the confirmation process. Signatures are required to make this portable order set valid. It is helpful to summarize the discussion and check for agreement with the individual.
  - Questions that are helpful include: “Can you tell me your understanding of the decisions we discussed?” “Do these decisions make sense given your preferences?”
Also, helpful is to ask open-ended questions such as, “What questions do you have?” and/or to revisit sections of the document.

Lastly, it can be helpful to suggest the patient take some time to reflect on the discussion and arrange a follow-up visit to finalize later.

- To be considered complete and valid, these orders are signed by either the patient or the patient representative and the clinician.
- In Section E, the patient or patient representative signs. If someone besides the patient is signing it is helpful to note if they are acting as a surrogate on behalf of the patient in the blank designated “Authority” and to print their full name as well as signing.

Section E: Patient or Patient Representative Signature

<table>
<thead>
<tr>
<th>E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The most recently completed valid POLST form supersedes all previously completed POLST forms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>If other than patient, print full name: Authority:</td>
</tr>
</tbody>
</table>

Section F: Health Care Provider Signature

- In Section F, the clinician must sign this document providing their signature and printed full name and their license number. It is important to look at your specific state regulations about who is authorized to sign these types of orders and if, in cases where someone other than a physician signs, whether a supervising physician signature is recommended or required. This signature attests that the health care provider had a conversation with the patient/surrogate.

<table>
<thead>
<tr>
<th>F. SIGNATURE: Health Care Provider (eSigned documents are valid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Full Name: License/Cert. #:</td>
</tr>
<tr>
<td>Supervising physician signature:</td>
</tr>
</tbody>
</table>

Step 6: Additional Contact Information (Reverse Side of POLST form)

It is optional, but very helpful, to record the patient’s emergency contact info, whether they are serving as a legal representative, the name and phone of their primary care provider and hospice information if the patient is enrolled in a hospice.
Contact Information: (Back side of Form)

Patient Full Name:

<table>
<thead>
<tr>
<th>Contact Information (Optional but helpful)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)</td>
</tr>
<tr>
<td>Full Name:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Primary Care Provider Name:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>□ Patient is enrolled in hospice</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- It is also helpful to confirm that review of completed advance directives has occurred, or to note if for some reason, advance directives such as the Medical Power of Attorney and/or the Directive to Physicians and Families or Surrogates/Living Will were not reviewed. It is a best practice to ensure that the choices noted on the advance directives and the POLST match.

- Identify who participated in the discussion as well as naming any individual who serves as part of the health care team who assisted in conducting the conversation. This allows for easier understanding about questions the patient/family or the physician and care team members may have.

Form Completion Information: (Back side of Form)

<table>
<thead>
<tr>
<th>Form Completion Information (Optional but helpful)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed patient’s advance directive to confirm no conflict with POLST orders:</td>
</tr>
<tr>
<td>(A POLST form does not replace an advance directive or living will)</td>
</tr>
<tr>
<td>Yes; date of the document reviewed:</td>
</tr>
<tr>
<td>□ Conflict exists, notified patient (if patient lacks capacity, noted in chart)</td>
</tr>
<tr>
<td>□ Advance directive not available</td>
</tr>
<tr>
<td>□ No advance directive exists</td>
</tr>
<tr>
<td>Check everyone who participated in discussion:</td>
</tr>
<tr>
<td>□ Patient with decision-making capacity</td>
</tr>
<tr>
<td>□ Court Appointed Guardian</td>
</tr>
<tr>
<td>□ Parent of Minor</td>
</tr>
<tr>
<td>□ Legal Surrogate / Health Care Agent</td>
</tr>
<tr>
<td>□ Other:</td>
</tr>
<tr>
<td>Professional Assisting Health Care Provider w/ Form Completion (if applicable):</td>
</tr>
<tr>
<td>Full Name:</td>
</tr>
<tr>
<td>Date (mm/dd/yyyy):</td>
</tr>
<tr>
<td>Phone #: ( )</td>
</tr>
<tr>
<td>This individual is the patient’s:</td>
</tr>
<tr>
<td>□ Social Worker</td>
</tr>
<tr>
<td>□ Nurse</td>
</tr>
<tr>
<td>□ Clergy</td>
</tr>
<tr>
<td>□ Other:</td>
</tr>
</tbody>
</table>

- There is an informational section that contains other completion instructions and reminders.

- Finally, some institutions like to record other patient identifying information such as a barcode or Medical Record Number.
Form Information/Instructions – (Back side of Form)

Form Information & Instructions

- 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](http://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](http://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.

State Specific Info

<table>
<thead>
<tr>
<th>For Barcodes / ID Sticker/Medical Record #</th>
</tr>
</thead>
</table>

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For more information, visit [www.polst.org](http://www.polst.org)

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

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.
# 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>Preferred name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Name/initial:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td>Suffix (jr, sr, etc):</td>
</tr>
</tbody>
</table>

DOB (mm/dd/yyyy): __/__/____ State where form was completed:

Gender: [ ] M [ ] F [ ] X Social Security Number’s last 4 digits (optional): xxx-xx-____

---

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

<table>
<thead>
<tr>
<th>Pick</th>
<th>YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)</th>
<th>NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)</th>
</tr>
</thead>
</table>

---

### 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.

<table>
<thead>
<tr>
<th>Pick1</th>
<th>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.</th>
<th>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.</th>
</tr>
</thead>
</table>

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 setting.

---

### 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)

<table>
<thead>
<tr>
<th>Pick1</th>
<th>Provide feeding through new or existing surgically-placed tubes</th>
<th>No artificial means of nutrition desired</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trial period for artificial nutrition but no surgically-placed tubes</td>
<td>Not discussed or no decision made (provide standard of care)</td>
</tr>
</tbody>
</table>

---

### 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)

If other than patient, print full name: Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

---

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

Verbal orders are acceptable with follow up signature.

(required)

Printed Full Name: License/Cert. #: License #: Phone #: Date (mm/dd/yy): Required

[Note: Only licensed health care providers authorized by law to sign POLST forms in state where completed may sign this order]

---

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019
# National POLST Model Form – Page 2

## Patient Full Name:

### Contact Information (Optional but helpful)

Patient’s Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

- **Full Name:**
  - [ ] Legal Representative
  - [ ] Other emergency contact

- **Phone #:**
  - Day: ( )
  - Night: ( )

- **Primary Care Provider Name:**

- **Name of Agency:**

- **Agency Phone:** ( )

- **Patient is enrolled in hospice**

### Form Completion Information (Optional but helpful)

Reviewed patient’s advance directive to confirm no conflict with POLST orders:

- [ ] Yes; date of the document reviewed: __________________
- [ ] Conflict exists, notified patient (if patient lacks capacity, noted in chart)
- [ ] Advance directive not available
- [ ] No advance directive exists

Check everyone who participated in discussion:

- [ ] Patient with decision-making capacity
- [ ] Court Appointed Guardian
- [ ] Parent of Minor
- [ ] Legal Surrogate / Health Care Agent
- [ ] Other: __________________

Professional Assisting Health Care Provider w/ Form Completion (if applicable):

- **Full Name:** __________________
- **Date (mm/dd/yyyy):** / /
- **Phone #:** ( )

### This individual is the patient’s:

- [ ] Social Worker
- [ ] Nurse
- [ ] Clergy
- [ ] Other: __________________

### Form Information & Instructions

#### 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 to 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](http://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](http://www.polst.org/form)

#### State Specific Info

#### For Barcodes / ID Sticker/Medical Record #

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