HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

MINNESOTA

Provider 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. Patients should always be treated with dignity and respect.

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

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

CHECK ONE

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

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

When not in cardiopulmonary arrest, follow orders in B.

B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE

(NOTE REQUIREMENTS)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** 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. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** 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.

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

☐ **Patient** (*Patient has capacity)* ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**

☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ***(STRONGLY RECOMMENDED)*** | NAME *(PRINT)*

RELATIONSHIP *(IF YOU ARE THE PATIENT, WRITE "SELF")* | PHONE *(WITH AREA CODE)*

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D SIGNATURE OF PHYSICIAN / APRN / 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.

NAME *(PRINT)* ***(REQUIRED)*** | LICENSE TYPE ***(REQUIRED)*** | PHONE *(WITH AREA CODE)*

SIGNATURE ***(REQUIRED)*** | DATE ***(REQUIRED)***

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

INFORMATION FOR _____

PATIENT NAMED ON THIS FORM

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

CHECK ONE FROM EACH SECTION

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

☐ **Long-term artificial nutrition by tube.**

☐ **Defined trial period of artificial nutrition by tube.**

☐ **No artificial nutrition by tube.**

ANTIBIOTICS

☐ **Use IV/IM antibiotic treatment.**

☐ **Oral antibiotics only (no IV/IM).**

☐ **No antibiotics. Use other methods to relieve symptoms when possible.**

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

_____

_____

HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

PREPARER NAME ***(REQUIRED)*** _____ PREPARER TITLE ***(REQUIRED)*** _____

PREPARER PHONE *(WITH AREA CODE)* ***(REQUIRED)*** _____ DATE PREPARED ***(REQUIRED)*** _____

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is 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. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a Health Care Agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, Health Care Agent designated in a Health Care Directive, or a person whom the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a verbally designated surrogate, spouse, registered domestic partner, parent of a minor, or closest available relative.

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 Medical Care Provider 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.
- If included in an electronic medical record, follow voiding procedures of facility/community.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*