Provider Order for Life Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.0 December 2014 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name | First Name/Middle Initial | Effective Date of this Order

Date of Birth | Last 4 of SS# | Address (street/city/state/zip)

Medical Provider's Name (MD/DO/PA/APRN) | Medical Provider's Phone

Brief description of patient's medical condition

Patient's stated goals for medical care

A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

- ☐ Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
- ☐ Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
- ☐ I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

- ☐ **FULL TREATMENT:** Prolonging life by all medically effective means. Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vassopressors, and any other life sustaining care that is required. Also includes medical care described below.
  Describe goals and/or time period if a trial is desired:
- ☐ **LIMITED ADDITIONAL INTERVENTIONS:** Treating medical conditions while avoiding burdensome measures. Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.
  Describe goals and/or time period if a trial is desired:
- ☐ **COMFORT MEASURES:** MAXIMIZING comfort and dignity
  Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.
- ☐ **NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment)

Other instructions or clarification:

C. ARTIFICIAL NUTRITION

- ☐ Long term artificial nutrition with feeding tube
- ☐ Trial period of artificial nutrition with feeding tube
- ☐ No artificial nutrition
- ☐ I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

- ☐ Advance Directive available, reviewed and confirmed without conflicts
- ☐ No Advance Directive available

Healthcare agent named in Advance Directive | Phone Number

- ☐ I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
- ☐ I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name | Relationship: (write self if patient) | Signature

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

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DIRECTIONS FOR HEALTHCARE PROVIDERS

COMPLETING POLST

- This form is intended for both adult and pediatric patients.
- The POLST is not an Advance Directive and does not replace it. The POLST is a Medical Order.
- When available, review the Advance Directive and POLST form to ensure consistency.
- The POLST must be completed by a medical provider (MD/DO/PA/APRN) based on patient preferences and medical indications.
- The entire form should be completed. A patient may indicate that they "do not wish to express a preference" rather than leaving a section of the form blank.
- Section D, which indicates the degree of leeway the patient would like to grant their surrogate, must be completed by the individual patient and only if the patient has medical decision-making capacity.
- The POLST must be signed by the patient or surrogate decision maker AND by a medical provider (MD/DO/PA/APRN) to be valid. In the case of pediatric patients, signatures from two different medical providers are required.
- Verbal orders are acceptable with follow up signature in accordance with organization/community policy.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid.

USING POLST

Section A:

- If a patient has selected "Do Not Attempt Resuscitation" and is **found pulseless and not breathing**, no defibrillator (including automated external defibrillators) or chest compressions should be used.

Section B:

- A person may chose "DNR" in Section A and "Full Treatment" in Section B, recognizing in Section A the setting refers to where there are no signs of life (palpable pulse) and Section B refers to the setting where there are signs of life.
- Choosing "Attempt to resuscitate" in Section A requires "Full treatment" in Section B as an attempt at resuscitation may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, and/or vassopressors.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures," may be transferred to the hospital to provide comfort (e.g., treatment of hip fracture).
- If a patient has indicated that he/she would not want to return to the hospital, this should be written in the "other instructions and clarifications" section of the form.
- IV antibiotics and fluids are generally not considered "Comfort Measures" and may prolong life. A person who desires IV fluids or IV antibiotics should indicate "Limited Additional Interventions" or "Full Treatment."
- Some IV medications (e.g. medication for pain, nausea, delirium, etc.) may be appropriate for a patient who has chosen "Comfort Measures."

REVIEWING POLST

This form should be reviewed periodically (consider at least annually). Review is also recommended when:

- The patient is transferred from one care setting or care level to another.
- There is a substantial change in the patient's health status.
- The patient's treatment preferences change.

MODIFYING AND VOIDING POLST

- The POLST form can be modified at any time if a patient changes his/her mind about his/her treatment preferences by completing a new POLST form.
- If a patient has given sufficient leeway to his/her surrogate to modify the POLST form, any modifications made should be in collaboration with the medical provider.
- It is recommended that revocation of the form be documented by drawing a line through sections A through D, writing "VOID" in large letters, and signing/dating the form.
- The most recently dated POLST is considered the valid POLST. The most recently dated POLST orders supersede all prior POLST directives.

Place this form in a prominently visible part of the patient's record or home. A copy of this form must accompany the patient when transferred or discharged (including transfers to hospital emergency departments).