



Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A *Check One* **CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse and is not breathing.*

Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR (Allow Natural Death)
(Section B: Full Treatment required)

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

B *Check One* **MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*

Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer if comfort needs cannot be met in current location.*

Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure) *Transfer* to hospital if indicated. Avoid intensive care.

Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C *Check One* **ARTIFICIALLY ADMINISTERED NUTRITION:** *Always offer food and liquid by mouth if feasible and desired.*
(See Directions on next page for information on nutrition & hydration)

No artificial nutrition by tube. Defined trial period of artificial nutrition by tube.
Goal: _____

Long-term artificial nutrition by tube.

Additional Orders: _____

D **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**

Discussed with:
 Patient Patient's Surrogate (Health Care Decision-maker) Parent of Minor Guardian

Signature of Physician
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Surrogate, Parent of Minor or Guardian
 By signing this form, the legally recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and in the best interests of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
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Summary of Medical Condition	Office Use Only
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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Current Address			
Contact Information			
Patient's Surrogate (Health Care Decisionmaker)	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional**Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/surrogate to be valid. Verbal orders are not acceptable.
- A surrogate may be designated by a patient or if the patient lacks capacity to consent to or refuse treatment, a non-designated surrogate may be appointed by consensus of the interested persons as per HRS §327E-5.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:

- A surrogate who is not designated by the patient may make all health-care decisions for the patient except that artificial nutrition and hydration may be withheld or withdrawn only when the primary physician and a second independent physician certify in the medical records that the provision/continuation of nutrition/hydration prolongs the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

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

Modifying and Voiding POLST

- A person with capacity or, if lacking capacity, the surrogate can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through D and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's physician may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kokua Mau – The Hawaii Hospice and Palliative Care Organization

Kokua Mau is the lead agency for implementation of POLST in Hawaii. This form has been adopted by the Department of Health (*August 2009*). For more information or to download a copy, visit www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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