02/2013 **NEW HAMPSHIRE**

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Provider Orders for Life-Sustaining Treatment (POLST)

This is a Physician/APRN Order Sheet. First follow these orders, then contact physician or APRN. 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.

Last Name of Patient		
First Name/Middle Initial for Patient		
Date of Birth (mm/dd/yyyy) _____, _____, _____	Last 4 SSN ☐☐☐☐	Gender ☐M ☐F

Section A *Check One*

Cardiopulmonary Resuscitation (CPR): Patient has no pulse or is not breathing.

☐ Attempt CPR

☐ Do Not Resuscitate/DNR (**The PINK Portable-DNR must accompany the POLST for DNR to be in effect in all NH settings.**)

Follow orders in **B, C** and **D** when not in cardiopulmonary arrest.

Section B *Check One*

Medical Interventions: Patient has pulse and/or is breathing.

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

☐ **Limited Interventions** – Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital level of care to meet need, if indicated. Avoid intensive care.*

☐ **Comfort-focused Care** – Use medication by any route, positioning, wound care and other measures to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment. Transfer to more acute level if comfort needs cannot be met in current location.*

Other Instructions:_____

Section C *Check Only One in Each Column*

Medically Administered Fluids and Nutrition. Oral fluids and nutrition must be offered if medically feasible and consistent with patient's goals of care.

☐ IV fluids long-term	☐ Feeding tube long-term
☐ IV fluids for a defined trial period (provide other measures to assure comfort)	☐ Feeding tube for a defined trial period
☐ No IV Fluids (provide other measures to assure comfort)	☐ No feeding tube

Other Instructions:_____

Section D *Check One*

☐ Antibiotics if indicated clinically or by testing. ☐ Antibiotics only if likely to contribute to comfort

☐ No antibiotics

Other Instructions:_____

Section E *Check All That Apply*

Discussed with:	**The basis for these orders is:**
☐ Patient	☐ Patient's preference
☐ DPOAH Representative	☐ Activated Durable Power of Attorney for Healthcare (DPOAH)
☐ Court-appointed guardian	☐ Activated Living Will
☐ Parent(s) of minor	☐ Parent of Minor
☐ Other:_____(specify)	☐ Guardianship
	☐ Other:_____(specify)

Documentation of discussion is located in medical chart at:

Date of Discussion:

Mandatory Signature of Patient or DPOAH, Guardian or Parent of Minor, and Physician/ARPN

Name (Print)	**Signature** (Mandatory)	**Date**	**Relationship** (write "self" if patient)
Physician/APRN Name: (Print)	**Physician/APRN Phone Number:**	**Physician/APRN State License Number:**	
Physician/APRN Signature: (Mandatory)		**Date:**	

HIPAA PERMITS DISCLOSURE TO HEALTH PROFESSIONALS INVOLVED IN THE PATIENT'S CARE

Information for Patient Named on this form – Patient's Name (print):_____

This voluntary form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by you and your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your DPOAH, Guardian or by your written Advance Care Plan.

(Optional) Contact Information for DPOAH, Guardian or Parent of Minor

Name:	Relationship:	Phone Number:	Address:

(Optional) Health Care Professional Preparing Form

Name:	Preparer Title:	Phone Number:
		Date Prepared:

Directions for Health Care Professionals

Completing POLST

- Encourage completion of an Advance Directive.
- Should reflect current preferences of patient with serious illness or frailty whose death within the next year would not surprise you.
- Verbal/phone orders are acceptable with follow-up signature by physician/APRN in accordance with facility policy.
- Use original form if patient is transferred/discharged.

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.

Voiding POLST

- A patient with capacity, or the activated DPOAH or Court appointed Guardian of a patient 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.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Signature
Review Outcome: ☐ No Change		☐ Form Voided	☐ New form completed
Review Date	**Reviewer**	**Location of Review**	**Signature**
Review Outcome: ☐ No Change		☐ Form Voided	☐ New form completed
Review Date	**Reviewer**	**Location of Review**	**Signature**
Review Outcome: ☐ No Change		☐ Form Voided	☐ New form completed

ORIGINAL TO ACCOMPANY PATIENT IF TRANSFERRED / DISCHARGED

FOUNDATION FOR HEALTHY COMMUNITIES
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