POLST OREGON

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT®

Health care providers are authorized to print Oregon POLST Forms for use with their patients. The Oregon POLST Form remains a copyright protected document and in order to print the form certain guidelines must be followed.

Requirements and information for printing Oregon POLST Forms

- The form must not be altered in **any way** including the overall layout, text, or images.
- Copy or print forms on 65# Cover Ultra Pink card stock*
- Both side of the form must be printed back to back and not on separate pages
- A POLST Form requires a signature from an MD, DO, PA, or NP to be valid and should only be filled out and signed after an in-depth conversation between the patient and health care provider about the patient's goals of care
- The Oregon POLST Form is updated every two to three years. Please check back periodically to make sure that you are using the most current version of the form
- Forms differ from state to state depending on local laws and requirements. If you are a patient or provider outside of Oregon visit www.polst.org to find out about POLST Programs and Forms in your state
- Written authorization is still required to reproduce the Oregon POLST Form for purposes other than patient care. To request authorization email polst@ohsu.edu.

If you have questions about the Oregon POLST Program or Oregon POLST Form visit www.orpolst.org

*Mohawk BriteHue Ultra Pink card stock is available online and at some retailers.
Suggested online vendors for Ultra Pink card stock:
Med-Pass - www.med-pass.com
Boyd's Imaging Products - www.iboyds.com
Mohawk Paper Store - www.mohawkpaperstore.com

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician 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.
For more information on Oregon POLST visit: www.orpolst.org

Patient Last Name:	Patient First Name	Middle Int.
Date of Birth: (mm/dd/yyyy) _____ _____ _____	Gender: ☐ M ☐ F	Last 4 SSN: ☐☐☐☐
Address: (street / city / state / zip)		

A — Cardiopulmonary Resuscitation (CPR): *Patient has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

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

B — Medical Interventions: *If patient has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** (**A**llow **N**atural **D**eath). 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.

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, 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.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: _____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible.*

Check One

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____
_____
_____

D — Documentation of Discussion:

☐ Patient (Patient has capacity)
☐ Parent of minor
☐ Court-Appointed Guardian
☐ Health Care Representative or legally recognized surrogate
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
☐ Other _____

Signature of Patient or Surrogate

Signature: ***recommended***	Name (print):	Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

E — Signature of Physician / NP/ 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.

Print Signing Physician / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*
Physician / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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Information for patient named on this form PATIENT'S NAME: _____

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

Contact Information

Surrogate (optional):	Relationship:	Phone Number:	Address:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:

PA's Supervising Physician:	Phone Number:

Primary Care Professional:

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf.

Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)

For the Oregon POLST Registry the following must be completed:

- Patient's full name
- Date of birth
- Section A
- MD / DO / NP / PA signature
- Date signed

Send a copy of both sides of this POLST form to the Oregon POLST Registry.

FAX or eFAX:
503- 418-2161
or
Mail:
Oregon POLST Registry
CDW-EM
3181 SW Sam Jackson Park Rd.
Portland, OR 97239

Date Submitted _____ /_____ /_____

MAY PUT REGISTRY ID STICKER HERE:

Registry Phone: 503-418-4083
*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.

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 care professional 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.
- Send a copy of the voided form to the POLST Registry as above (required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

