HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp *Revised 3/01/2014*

Montana Provider Orders For Life-Sustaining Treatment (POLST)

THIS FORM MUST BE SIGNED BY A PHYSICIAN, PA or APRN IN SECTION D TO BE VALID

If any section is NOT COMPLETE:
Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male ☐ Female ☐

Section A
Select only one box

Treatment Options: If patient does not have a pulse and is not breathing:

☐ **Attempt Resuscitation (CPR)**

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

If patient is not in cardiopulmonary arrest, follow orders found in sections **B** and **C**

Section B
Select only one box

Treatment Options: If patient has a pulse and/or is breathing:

☐ **Comfort Measures ONLY:** Relieve pain and suffering through the use of medication by any route, positioning, wound care or other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer to hospital ONLY if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions:** In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. *Transfer to hospital if indicated for treatment or comfort. Generally Avoid Intensive Care.*

☐ **Full Treatment:** In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. *Transfer to hospital if indicated. Include Intensive Care.*

Other Instructions: _____

Section C
Select only one box

Artificially Administered Nutrition: (Offer food and fluid by mouth if feasible and/or desired)

☐ **No Artificial Nutrition by Tube.**

☐ **Defined trial period of Artificial Nutrition by Tube. Specifically:** _____

☐ **Long Term Artificial Nutrition by Tube.**

Section D
Select box(es)

Discussed With:

☐ **Patient** ☐ **Health Care Agent or Decision-Maker** ☐ **Court Appointed Guardian**

☐ **Other** _____

By signing below, the decision-maker acknowledges that these orders are consistent with the known desires of the patient.

Signature of Patient or Decision-Maker (required)	**Printed Name**	**Relationship if not Patient**

Name of Person Preparing Form	**Phone Number of Preparer**	**Date Form Prepared**

Signature of Provider: *My signature below indicates to the best of my knowledge that these orders are consistent with the medical conditions and preferences of the patient.*

Signature of Physician, PA, or APRN (required)	**Printed Name of Physician, PA or APRN**

Date and Time	*Provider Phone Number*

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED CARE LEVELS OR TO HOME
Use of the original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid.

Directions for Health Care Professionals

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications. POLST **must be signed** by patient or decision-maker to be valid. Verbal orders are acceptable with follow-up signature by physician 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

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

Section A:

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

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (i.e. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.

Reviewing POLST

- POLST review is recommended periodically and when:
  - The patient is transferred from one care setting or care level to another
  - There is substantial change in the patient's health care status
  - The patient has a change in treatment preference

Modifying and Voiding POLST

- A patient or decision-maker can at any time void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or completing a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign.
- The most recently dated POLST is considered the valid POLST. The most recently dated POLST's wishes/orders supersede all prior POLST directives.