HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT 10/17

Physician Orders for Life-Sustaining Treatment (POLST) Maine

First follow these orders, **then** contact physician, NP or PA. 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 / First / Middle Initial**	
	Address:	
	City / State / Zip:	
	Date of Birth:	**Gender: M F**

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

___Attempt Resuscitation/CPR ___Do Not Attempt Resuscitation/DNR (Allow Natural Death)

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

B *Check One*

MEDICAL INTERVENTIONS: Patient 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. ***Do Not Transfer to Hospital*** *for life sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current setting.*

___**Limited Additional Interventions:** Includes all care described above. Use medical treatment and monitoring 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 if indicated.** *Avoid intensive care.*

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

Additional Orders:

C *Check One for part 1* ***And*** *One for part 2*

ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION: Offer food / liquids by mouth if feasible.

Part 1 – Nutrition:	**Part 2 – Hydration:**
___No artificial nutrition by tube	___No artificially administered fluids
___Trial period of artificial nutrition by tube. Goal:_____	___Trial period of artificial hydration. Goal:_____
___Long-term artificial nutrition by tube.	___Full treatment with artificially administered fluids.

Additional Orders:

D

BASIS FOR ORDERS

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences as indicated by:

Basis for determining patient's preferences (check all that apply)	**Discussion with**: (check all that apply)
___Advance Directive (on file)	___Patient
___Patient's current statement to Physician / NP / PA / or Other Health Care Professional	___Parent of a minor
___Patient's statement to authorized representative	___Guardian
___Best interest determined by authorized representative (no advance directive / preferences unknown)	___Health Care Agent
	___Other

Print Name of Primary Care Professional	**Phone:**
Print Name of Signing Physician / PA/ NP	**Phone:**
Signature of Physician / PA /NP (required)	**Date and Time:**

(Form continues on reverse side)

Patient Last Name:	**First Name:**	**DOB:**

E **Signature of Patient or Authorized Representative**

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

Signature	**Name (print)**	**Relationship (write 'self' if patient)**
Name of Authorized Representative	**Relationship**	**Address & Phone**

Health Care Professional Preparing Form	**Title**	**Phone**	**Date**

Directions for Health Care Professionals

Completing POLST

- This is a **voluntary** order.
- Should reflect patient's preferences based on **current** medical condition. Encourage completion of an advanced directive.
- POLST must be signed by a physician, nurse practitioner or physician assistant to be valid. Verbal orders are acceptable with follow up signature by the physician/NP/PA in accordance with facility /community policy.
- Use of original form is strongly encouraged. Photocopies and faxes are legal and valid.
- Patient should sign this form if (s)he is able to make his/her own health care decisions. If unable to sign, an authorized representative should sign.
- In the event of an emergency, changes may be made to the form by an Authorized Representative via telephone.
- An Authorized Representative includes, in order of priority, a health care agent (same as durable health care power of attorney or agent named in advance directive), court appointed guardian, parent of minor, or surrogate as defined in 18-A MRS § 5-801.

Using POLST

- **Section A**
- No defibrillator (including AED's) 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 patient, 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 patient who has chosen "Comfort Measures Only."

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.

Draw a line through sections A through D and write "VOID" in large letters if POLST is replaced or becomes invalid.

Obtaining Additional POLST forms

- Additional POLST forms may be obtained by contacting the Maine POLST Coalition, online at www.polstmaine.org

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED