



## **Introduction to the POLST Form**

Pennsylvania – Orders for Life Sustaining Treatment (POLST) is a medical order that gives patients more control over their end-of-life care. The POLST form specifies the types of medical treatment that a patient wishes to receive towards the end of life. These medical orders are signed by both a patient’s physician, physician’s assistant, or certified registered nurse practitioner and the patient or the patient’s surrogate

Completion of a POLST form is only a small step in the process of a patient’s decision-making, and it is critical that this form be used as part of a program for end of life decisions that includes educational support and other aspects of planning for providers and patients.

This form was developed by the Pa. Department of Health’s Patient Life Sustaining Wishes Committee and was designed to be consistent with Pennsylvania law. There are significant advantages to using a form that contains standardized language and is produced in a distinctive and easily recognizable format. In order to maintain continuity throughout Pennsylvania, please follow these printing instructions:

**\*\*\* Print POLST form on Pulsar Pink card stock (65#) \*\*\***

See additional instructions on the POLST form related to completing and using the form. As additional educational materials are developed for the POLST form and for POLST programs in Pennsylvania, they will be added to this introduction.

11/10/10

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**  
 To follow these orders, an EMS provider must have an order from his/her medical command physician



**Pennsylvania  
 Orders for Life-Sustaining  
 Treatment (POLST)**

Last Name
First/Middle Initial
Date of Birth

**FIRST** follow these orders, **THEN** contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

<b>A</b> Check One	<b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse <u>and</u> is not breathing.</b>
	<input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in <b>B, C</b> and <b>D</b> .

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</b>
	<input type="checkbox"/> <b>COMFORT MEASURES ONLY</b> Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. <b>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</b>
	<input type="checkbox"/> <b>LIMITED ADDITIONAL INTERVENTIONS</b> Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <b>Transfer to hospital if indicated. Avoid intensive care if possible.</b>
	<input type="checkbox"/> <b>FULL TREATMENT</b> Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <b>Transfer to hospital if indicated. Includes intensive care.</b> Additional Orders _____

<b>C</b> Check One	<b>ANTIBIOTICS:</b>	<b>D</b> Check One	<b>ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:</b>
	<input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs, with comfort as goal <input type="checkbox"/> Use antibiotics if life can be prolonged Additional Orders _____		Always offer food and liquids by mouth if feasible <input type="checkbox"/> No hydration and artificial nutrition by tube. <input type="checkbox"/> Trial period of artificial hydration and nutrition by tube. <input type="checkbox"/> Long-term artificial hydration and nutrition by tube. Additional Orders _____

<b>E</b> Check One	<b>SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:</b>	
	Discussed with <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other:	<b>Patient Goals/Medical Condition:</b>

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Physician /PA/CRNP Printed Name:	Physician /PA/CRNP Phone Number
Physician/PA/CRNP Signature (Required):	DATE
Signature of Patient or Surrogate	
Signature (required)	Name (print)
Relationship (write "self" if patient)	

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**Other Contact Information**

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

**Directions for Healthcare Professionals**

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. [www.health.state.pa.us](http://www.health.state.pa.us)

**Completing POLST**

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary

**Using POLST**

If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation"

Oral fluids and nutrition must always be offered if medically feasible.

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).

A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

**Review**

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

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

**Revoking POLST**

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write "VOID" in large letters across the form, and sign and date the form.