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

**Patient Information**

| Full Name | Date of Birth | Gender |
|---|---|---|
| | | |

**Physician**

| Printed Name | Phone Number |
|---|---|
| | |

**Patient's Additional Contact**

| Printed Name | Phone Number |
|---|---|
| | |

## Directions for Physician Completing POLST Form

### Completing the POLST Form

- **No patient is required to complete a POLST form.** The patient (or legal representative) signs the form to indicate the voluntary nature of the form and that the contents of the form are consistent with the patient's desires and values.
- **Upon arrival at or admission to a hospital or other facility, the POLST establishes initial treatment of the patient.** After evaluation of the patient in the hospital or other facility, additional appropriate orders may be issued consistent with the patient's preferences.
- **POLST does not replace a living will or other advance directive.** When available, review the advance directive and POLST form to ensure consistency and update forms appropriately to resolve any conflicts.
- **POLST must be completed by a physician based on patient preferences and values and medical indications.**
- **The legal representative of a patient may sign the POLST form if the patient lacks capacity.** A legal representative may include a court-appointed guardian, an agent designated in an advance directive, a spouse, an adult child, an adult sibling, an adult relative, or another surrogate whom the physician believes has exhibited special care and concern for the patient, is familiar with the patient's values, and will make decisions according to the patient's wishes and values.
- **To be valid, a POLST form must be signed by a physician and the patient or legal representative.** Both signatures are required.
- **If a translated POLST form is used with the patient or legal representative, attach the translation to the signed English POLST form.**
- **It is recommended that the POLST form be printed on bright pink paper, so it can be easily recognized among the patient's paperwork.** Use of the original POLST form is encouraged, but photocopies and faxes are legal and valid under Arkansas law.
- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**

### Using POLST

- An incomplete section of the POLST form implies full treatment for that section.

*Section A:*

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions 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-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment." If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."

*Section C:*

- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**
- Depending on local EMS protocol, "Additional Orders" written in Section C may not be implemented by EMS personnel.

### Reviewing POLST

It is recommended that POLST be reviewed periodically. In addition, review is recommended when:

- 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.

### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means indicating intent to revoke.
- It is recommended that revocation be documented by drawing a line through Sections A through C, writing "VOID" in large letters, and signing and dating this line. A legal representative of a patient who lacks capacity may request to modify the orders after consulting with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or a copy of the POLST form, visit www. healthy.arkansas.gov.

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**

# Arkansas Department of Health

5800 West Tenth Street Suite 400 ● Little Rock, Arkansas 72205-3867 ● Telephone (501) 661-2201
**Governor Asa Hutchinson**
**Nathaniel Smith, MD, MPH, Director and State Health Officer**
**http://www.healthy.arkansas.gov**


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## PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

| First follow these orders, then contact **Physician**.<br>A copy of the executed POLST form is a legally binding, valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.** | Patient Last Name: | Date form Prepared: |
|---|---|---|
| | Patient First Name: | Patient Date of Birth: |
| | Patient Middle Name: | |

**A** *Check One*

**CARDIOPULMONARY RESUSCITATION (CPR):** ***If patient has no pulse and is not breathing.***
***NOTE … If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

**B** *Check One*

**MEDICAL INTERVENTIONS:** ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort Treatment, use medical treatment and IVs as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

**C**

**ADDITIONAL ORDERS:**

**D**

**INFORMATION AND SIGNATURES:**

**Discussed with:** ☐ Patient (Patient Has Capacity) ☐ Legal Representative

☐ Advance Directive dated _____, available and reviewed
☐ Advance Directive not available.
☐ No Advance Directive.

**Signature of Physician** My signature below indicates to the best of my knowledge these orders are consistent with the patient's intentions and medical condition.

| Print Physician Name: | Physician Phone Number: | Physician License #: |
|---|---|---|
| Physician Signature: *(required)* | | Date: |

**Signature of Patient or Legal Representative** I am aware my consent to this form is voluntary. By signing this form, a legal representative acknowledges this request regarding resuscitative measures is consistent with the known wishes of, and with the best interest of, the individual who is the subject of the form.

| Print Name: | Relationship: *(write self if patient)* |
|---|---|
| Signature: *(required)* | Date: |
| Mailing Address: | Phone: |

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**