

provider is not yet aware of, or needs more information about the POLST form, please have them contact the Washington State Medical Association at 1 (800) 552-0612.

### Organizations that Endorse the Use of the POLST Form

- Association of Washington Public Hospital Districts
- Washington State Department of Health
- Washington State Hospice & Palliative Care Organization
- Washington State Hospital Association
- Washington State Medical Association
- Regional Ethics Network of Eastern Washington and Northern Idaho

More information about the POLST form can be found at the Washington State Medical Association website at [www.wsma.org/patient\\_resources/polst](http://www.wsma.org/patient_resources/polst).



2033 6th Avenue Suite 1100  
Seattle, WA 98121  
(206) 441-9762 or 1-800-552-0612



Department of Health  
Office of Emergency Medical & Trauma Prevention  
P.O. Box 47853  
Olympia, WA 98504-7853  
(360) 236-2828 or (800) 458-5281

# Physician Orders for Life-Sustaining Treatment (POLST) Form

A sample of a Physician Orders for Life-Sustaining Treatment (POLST) form. The form is titled "Physician Orders for Life-Sustaining Treatment" and includes sections for patient information, medical conditions, and treatment preferences. The form is partially obscured by a large text overlay.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS

Physician Orders for Life-Sustaining Treatment

First follow these orders. THEN follow the orders of the physician or PA-C. The POLST is a set of medical orders for emergency medical treatment for illness based on their current medical status. Not completed implies full treatment. Be treated with dignity and respect.

Last Name - First Name - Middle Initial  
Date of Birth Last 4 SSN Gender M F

Medical Conditions/Patient Goals:

**A** Check One  
 **CARDIOPULMONARY RESUSCITATION** Attempt Resuscitation  
 **Choosing DNAR** will include appropriate control of measures and may include treatments below. When not in cardiopulmonary arrest, go to part B.

**B** Check One  
 **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 **COMFORT MEASURES ONLY** Use medication by any route, positioning, to relieve pain and suffering. Use oxygen, oral suction and manual techniques as needed for comfort. Patient prefers no hospital transfer: EMS will not transport if transport indicated to provide adequate comfort.  
 **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use cardiac monitor as indicated. Do not use intubation or mechanical ventilation or respiratory support (e.g. CPAP, BiPAP). Transfer to hospital if indicated.  
 **FULL TREATMENT** Includes care described above. Use intubation, advanced ventilation, and cardioversion as indicated. Transfer to hospital if indicated.  
Additional Orders: (e.g. dialysis, etc.) \_\_\_\_\_

**C** SIGNATURES: The signatures below verify that these orders are consistent with the patient's condition, known preferences and best known information. The patient must be decisionally incapacitated and the person signing must be a physician, ARNP, PA-C, or legal surrogate.  
Discussed with:  
 Patient  
 Parent of Minor  
 Legal Guardian  
 Health Care Agent (DPOAHC)  
 Spouse/Other  
PRINT — Physician/ARNP/PA-C Name  
PRINT — Patient or Legal Surrogate Name  
PRINT — Patient or Legal Surrogate Signature (mandatory)  
Person has:  
 Health Care Directive (living will)  
 Durable Power of Attorney for Health Care  
 Living Will Review

## Information for patients and family members

The POLST form is intended for any individual with an advanced life-limiting illness.

If you have a serious health condition, you need to make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders.

Your physician may use the POLST form to write orders that indicate what types of life-sustaining treatment you want or do not want at the end of life.

The POLST form asks for information about:

- your preferences for resuscitation
- medical conditions
- the use of antibiotics
- artificially administered fluids and nutrition.

The POLST form is voluntary and is intended to:

- help you and your physician discuss and develop plans to reflect your wishes;
- assist physicians, nurses, health care facilities and emergency personnel in honoring your wishes for life-sustaining treatment;
- direct appropriate treatment by Emergency Medical Services personnel.

## FREQUENTLY ASKED QUESTIONS REGARDING THE POLST FORM

### Does the POLST form need to be signed?

Yes. A physician, nurse practitioner, or certified physician assistant (PA-C) must sign the bright green form in order for it to be a physician order that is understood and followed by other health care professionals.

### If I have a POLST form do I need an advanced directive too?

If you have a signed POLST form, it is recommended that you also have an advanced directive, though it is not required. You may obtain more information about advanced directives from your physician.

### What if my loved one can no longer communicate his/her wishes for care?

If you are the designated health care representative, you can speak on behalf of your loved one. A physician can complete the POLST form based on your understanding of your loved one's wishes.

### In what setting is the POLST form used?

The completed POLST form is a physician order form that will remain with you if you are transported between care settings, regardless of whether you are in the hospital, at home or in a long-term care facility.

### Where is the POLST form kept?

If you live at home you should keep the original bright green POLST form in a prominent location (e.g., on the front of the refrigerator, on the back of the bedroom door, on a bedside table, or in your medicine cabinet). If you reside in a long-term facility, your POLST form may be kept in your medical chart along with other medical orders.

### How do I obtain a copy of the POLST form?

From your physician or other health care provider. If your physician or other health care

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

### Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Last 4 #SSN \_\_\_\_\_ Gender M F  
 FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals: \_\_\_\_\_ Agency Info/Sticker \_\_\_\_\_

**A CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Check One  CPR/Attempt Resuscitation  DNAR/Do Not Attempt Resuscitation (Allow Natural Death)  
 Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

**B MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Check One  COMFORT MEASURES ONLY 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. Patient prefers no hospital transfer: EMS contact medical control to determine if transport indicated to provide adequate comfort.  
 LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.  
 FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.  
 Additional Orders: (e.g. dialysis, etc.) \_\_\_\_\_

**C SIGNATURES:** The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Spouse/Other:	<input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name X Physician/ARNP/PA-C Signature (mandatory)	Phone Number Date
PRINT — Patient or Legal Surrogate Name			Phone Number Date
<input checked="" type="checkbox"/> Patient or Legal Surrogate Signature (mandatory)			Date