pennsylvania
DEPARTMENT OF HEALTH

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. The POLST form travels with the patient to help assure that treatment preferences are honored across settings of care (hospital, nursing home, assisted living facility etc.).

Completion of a POLST form is an entirely voluntary process and 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.

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

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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.

A Check One

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

☐ CPR/Attempt Resuscitation ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

B Check One

MEDICAL INTERVENTIONS: Person 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, oral 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 location.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

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 _____

C Check One

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal

☐ Use antibiotics if life can be prolonged

Additional Orders

D Check One

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

Always offer food and liquids by mouth if feasible

☐ No hydration and artificial nutrition by tube.

☐ Trial period of artificial hydration and nutrition by tube.

☐ Long-term artificial hydration and nutrition by tube.

Additional Orders

E Check One

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

Discussed with
☐ Patient
☐ Parent of Minor
☐ Health Care Agent
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other:

Patient Goals/Medical Condition:

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.pa.gov or www.papolst.org

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.