Health care providers are authorized to print Oregon POLST Forms for use with their patients. The Oregon POLST Form remains a copyright protected document and in order to print the form certain guidelines must be followed.

**Requirements and information for printing Oregon POLST Forms**

- The form must not be altered in **any way** including the overall layout, text, or images.
- Copy or print forms on 65# Cover Ultra Pink card stock*
- Both side of the form must be printed back to back and not on separate pages
- A POLST Form requires a signature from an MD, DO, PA, or NP to be valid and should only be filled out and signed after an in-depth conversation between the patient and health care provider about the patient’s goals of care
- The Oregon POLST Form is updated every two to three years. Please check back periodically to make sure that you are using the most current version of the form
- Forms differ from state to state depending on local laws and requirements. If you are a patient or provider outside of Oregon visit [www.polst.org](http://www.polst.org) to find out about POLST Programs and Forms in your state
- Written authorization is still required to reproduce the Oregon POLST Form for purposes other than patient care. To request authorization email [orpolst@ohsu.edu](mailto:orpolst@ohsu.edu).

If you have questions about the Oregon POLST Program or Oregon POLST Form visit [www.or.polst.org](http://www.or.polst.org)

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*Mohawk BriteHue Ultra Pink card stock is available online and at some retailers.
Suggested online vendors for Ultra Pink card stock:
Med-Pass - [www.med-pass.com](http://www.med-pass.com)
Boyd’s Imaging Products - [www.iboyds.com](http://www.iboyds.com)
Mohawk Paper Store - [www.mohawkpaperstore.com](http://www.mohawkpaperstore.com)
# Physician Orders for Life-Sustaining Treatment (POLST)

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

**Patient Last Name:**

**Patient First Name:**

**Patient Middle Name:**

**Last 4 SSN:**

<table>
<thead>
<tr>
<th>Address: (street / city / state / zip):</th>
<th>Date of Birth: (mm/dd/yyyy)</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>

## A CARDIOPULMONARY RESUSCITATION (CPR):

- **Unresponsive, pulseless, & not breathing.**
  - **Attempt Resuscitation/CPR**
  - **Do Not Attempt Resuscitation/DNR**

## B MEDICAL INTERVENTIONS:

- **If patient has pulse and is breathing.**
  - **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments.** Transfer if comfort needs cannot be met in current location.
    - **Treatment Plan:** Provide treatments for comfort through symptom management.
  - **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated.** Generally avoid the intensive care unit.
    - **Treatment Plan:** Provide basic medical treatments.
  - **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer to hospital and/or intensive care unit if indicated.**
    - **Treatment Plan:** All treatments including breathing machine.

## C ARTIFICIALLY ADMINISTERED NUTRITION:

- **Offer food by mouth if feasible.**
  - **Long-term artificial nutrition by tube.**
  - **Defined trial period of artificial nutrition by tube.**
  - **No artificial nutrition by tube.**

## D DOCUMENTATION OF DISCUSSION: (REQUIRED)

- **See reverse side for add’l info.**
  - **Patient** (If patient lacks capacity, must check a box below)
  - **Health Care Representative** (legally appointed by advance directive or court)
  - **Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition** (Note: Special requirements for completion- see reverse side)

**Representative/Surrogate Name:**

**Relationship:**

## E PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT

- **Signature:** *recommended*
  - **This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box:**

## F ATTESTATION OF MD / DO / NP / PA (REQUIRED)

- **Signature:** *required*
  - **Date:** *required*

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient’s current medical condition and preferences.

**Print Signing MD / DO / NP / PA Name:** *required*

<table>
<thead>
<tr>
<th>Signer Phone Number:</th>
<th>Signer License Number: (optional)</th>
</tr>
</thead>
</table>

**MD / DO / NP / PA Signature:** *required*

**Office Use Only**

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HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for patient named on this form  PATIENT’S NAME:  

The POLST form is always voluntary and is usually for persons with serious illness or frailty. POLST records your wishes for medical treatment in your current state of health (states your treatment wishes if something happened tonight). Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. No form, however, can address all the medical treatment decisions that may need to be made. An Advance Directive is recommended for all capable adults and allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself. Consider reviewing your Advance Directive and giving a copy of it to your health care professional.

Contact Information (Optional)

Health Care Representative or Surrogate:  Relationship:  Phone Number:  Address:  

Health Care Professional Information

Preparer Name:  Preparer Title:  Phone Number:  Date Prepared:  

PA’s Supervising Physician:  Phone Number:  

Primary Care Professional:  

Directions for Health Care Professionals

Completing POLST

• Completing a POLST is always voluntary and cannot be mandated for a patient.
• An order of CPR in Section A is incompatible with an order for Comfort Measures Only in Section B (will not be accepted in Registry).
• For information on legally appointed health care representatives and their authority, refer to ORS 127.505 - 127.660.
• Should reflect current preferences of persons with serious illness or frailty. Also, encourage completion of an Advance Directive.
• Verbal / phone orders are acceptable with follow-up signature by MD/DO/NP/PA in accordance with facility/community policy.
• Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
• A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to Guidance for Health Care Professionals at www.or.polst.org.

Oregon POLST Registry Information

Health Care Professionals:
(1) You are required to send a copy of both sides of this POLST form to the Oregon POLST Registry unless the patient opts out.
(2) The following sections must be completed:
• Patient’s full name
• Date of birth
• MD / DO / NP / PA signature
• Date signed

Registry Contact Information:  Phone: 503-418-4083  Fax or eFAX: 503-418-2161  www.orpolstregistry.org  polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: CDW-EM
Portland, Or 97239

Patients:  Mailed confirmation packets from Registry may take four weeks for delivery.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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