POLST® OREGON

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT®

Facing Serious Illness: Make Your Wishes Known to your Health Care Professional

Your Guide to the Oregon POLST Program
Physician Orders for Life-Sustaining Treatment

Revised: February 19, 2015

This material was adapted with the permission of the Coalition for Compassionate Care of California.

Facing Serious Illness: Make Your Wishes Known Table of Contents

POLST OREGON

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT®

Your Guide to POLST
(Physician Orders for Life-Sustaining Treatment)

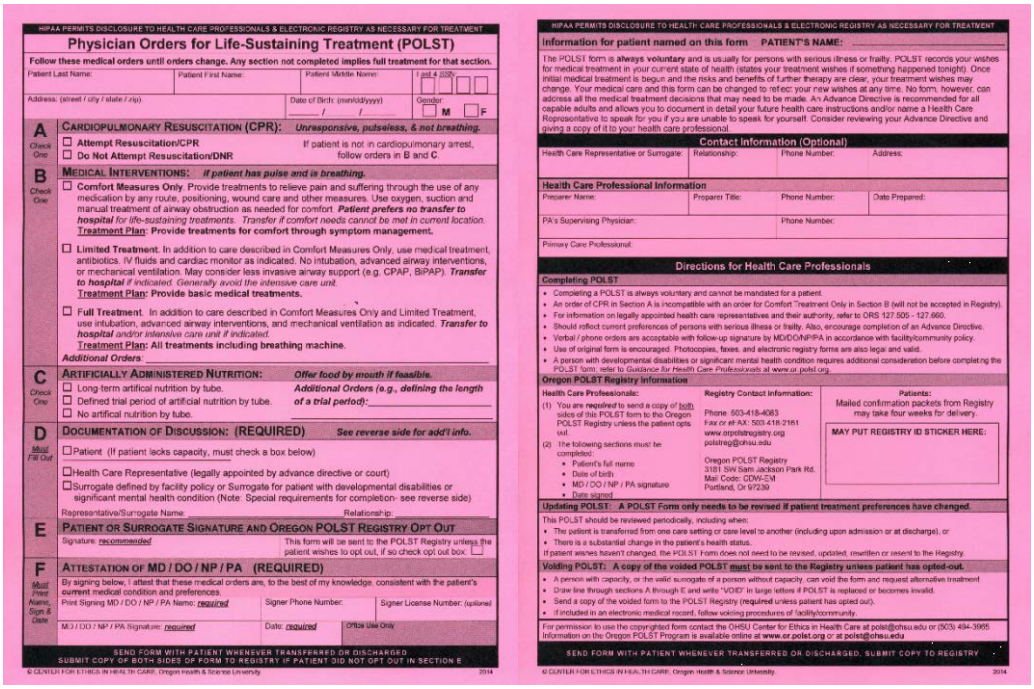
POLST: Why is it Important?

When you are seriously ill or frail it is very important to make sure your loved ones and health care professionals know what kinds of medical treatment you want, and do not want. The POLST (Physician Orders for Life-Sustaining Treatment) program was developed to help you achieve this goal.

POLST: What is it?

POLST is a medical order for people with serious illness or frailty. If you are someone with serious illness or frailty you can complete a POLST Form with your health care professional to direct the kinds of treatment you want in a medical crisis. POLST orders give you more control over the treatments you do or do not want to receive in an emergency situation. The form works to guide treatment decisions if you later lose the ability to speak for yourself.

The POLST order is signed by your physician, nurse practitioner or physician assistant after a discussion with you and/or a person who represents you. Since it is a medical order that will be followed in an emergency, it is important that it reflect your wishes *now*, in your *current* state of health.



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

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:

Address: (street / city / state / zip): | Date of Birth: (mm/dd/yyyy) | Gender: M F

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

☐ Attempt Resuscitation/CPR
☐ Do Not Attempt Resuscitation/DNR

If patient is not in cardiopulmonary arrest, follow orders in B and C

B Check One — **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.**

Additional Orders:

C Check One — **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.

Additional Orders (e.g., defining the length of a trial period):

D Must Fill Out — **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 Must Print Name, Sign & Date — **ATTESTATION OF MD / DO / NP / PA (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* | Signer Phone Number: | Signer License Number: *(optional)*

MD / DO / NP / PA Signature: *required* | Date: *required* | Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

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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 Treatment 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.

MAY PUT REGISTRY ID STICKER HERE:

Updating POLST: A POLST Form only needs to be revised if patient treatment preferences have changed.

This POLST should be reviewed periodically, including when:
- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes haven't changed, the POLST form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient has opted out.
- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry (**required** unless patient has opted out).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care at polst@ohsu.edu or (503) 494-3965. Information on the Oregon POLST Program is available online at **www.or.polst.org** or at **polst@ohsu.edu**

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

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Is POLST Required?

No. Filling out a POLST Form is completely up to you. It's your choice. It's always voluntary and can be changed any time at your request.

POLST: How is it Used?

The POLST Form is a medical order for recording patients' wishes about treatments that are commonly used in a medical crisis. Emergency personnel, such as paramedics, EMTs and emergency physicians, will follow these orders. Without a medical order, such as a POLST, paramedics and EMTs are required to provide every possible medical treatment to sustain life. An advance directive is not a medical order- so paramedics and EMTs cannot follow any wishes stated in that document. An advance directive can help guide your care once you are in the hospital and more is known about your condition.

The POLST Form is also helpful in guiding treatment after the initial emergency. It gives you a way to tell doctors, nurses, and other health care professionals what types of treatment you prefer. You can choose to have or forgo those medical treatments depending on your wishes and treatment plan. The form can be changed whenever your wishes change.

Because the POLST Form is not for future wishes—when your health may have deteriorated—it is very important that POLST orders show what treatments you want now, in your *current* state of health. These orders will be followed in a medical emergency so they must reflect the treatment you would want if that medical crisis were to happen today. The Advance Directive allows you to state your future wishes and is discussed below.

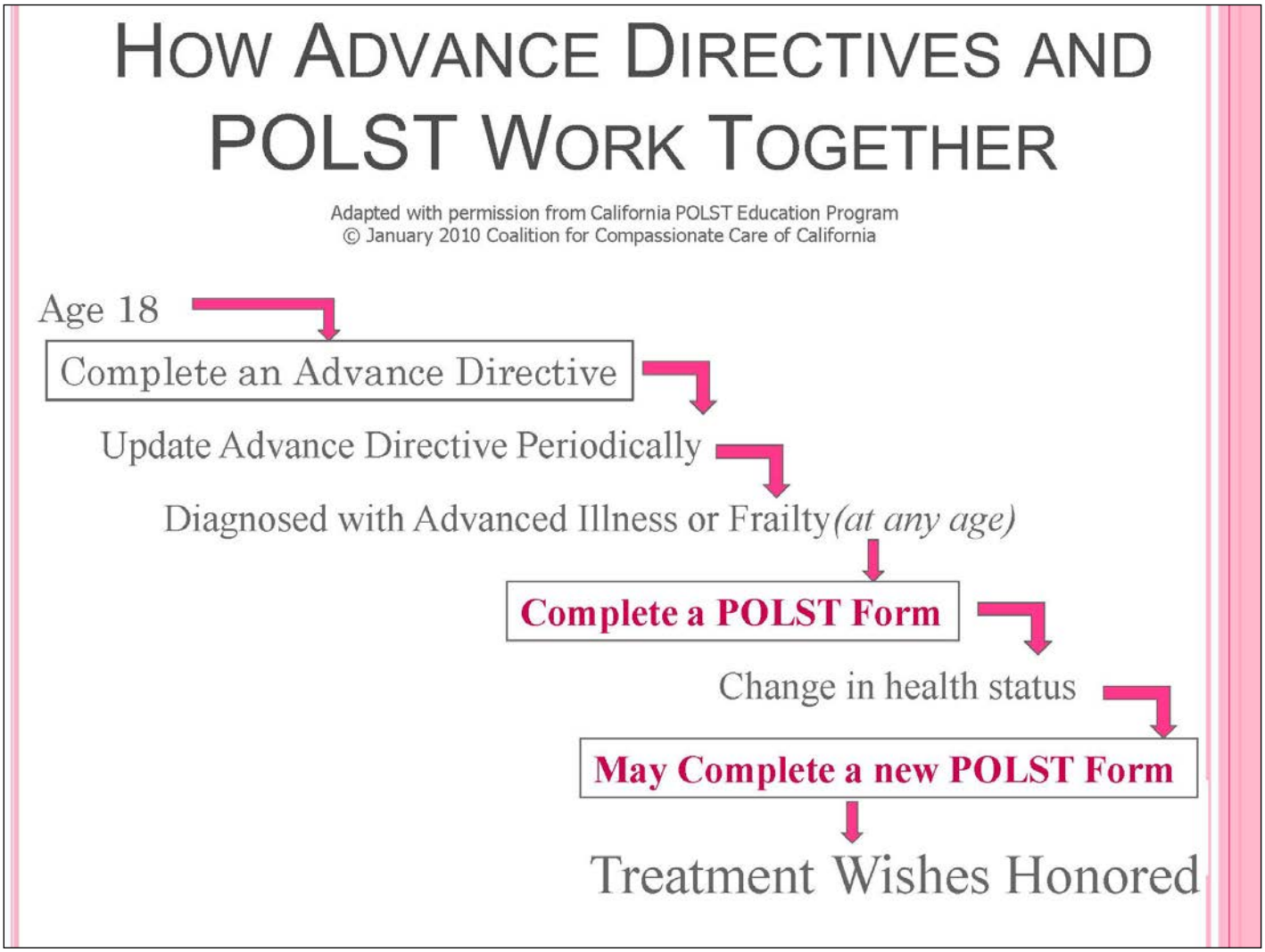
Should I Have a POLST Form?

POLST is for those with serious illness—such as advanced heart disease, advanced lung disease or cancer that has spread—or for those/who might be older and frail, and might not want to go to the Intensive Care Unit.

POLST is not for everyone. For example many people in their 60s are too healthy to need a POLST Form. If something suddenly happened, many healthy seniors would want everything done while more was learned about what was wrong and their chances of recovery. Healthy people should have an Advance Directive. Later, if you become sicker or frailer, you or your Health Care Representative can complete a POLST Form to turn your/treatment wishes into action.

This woman is in her 70s and in excellent health. She has an advance directive but is too healthy to have a POLST Form at this time.

How is POLST Different From an Advance Directive?



What is an Advance Directive?
Oregon's Advance Directive is for all capable adults—no matter your health status. Oregon's Advance Directive is the legal document that allows you to do two things:

- Choose a Health Care Representative—someone to make health care decisions for you if you are unable to speak for yourself
- Write down your wishes for future medical and life-sustaining treatments

When preparing an Advance Directive it is very important to talk with your loved ones and Health Care Representative about your future health care instructions.

Because an Advance Directive does not guide emergency care, the POLST Form was created for times of medical crisis. The Advance Directive and POLST work together to ensure your wishes are known. To learn more about completing an Advance Directive, go to: www.oregonhealthdecisions.org or www.caringinfo.org

How is the POLST Form Different?
POLST is different than an Advance Directive:

- POLST is for the seriously ill and frail, not all adults
- POLST describes your wishes about certain medical treatments now, in your *current* state of health
- POLST is a signed medical order for emergency personnel to follow in a medical crisis
- POLST orders go where you go—at home, the hospital, or your long-term care facility
- An Advance Directive allows you to document future treatment preferences when you cannot speak for yourself

POLST **Physician Order for Life-Sustaining Treatment**	**Advance Directive** **Oregon's Legal Form**
• For those with serious illness or frailty - at any age	• For all adults regardless of their health status
• Specific medical orders for ***current*** treatment. What patient would want today.	• Health Care Instructions for ***future or current*** life-sustaining treatments • Appoints a Health Care Representative (HCR)
• Orders signed by Health Care Professional. Encourage signature by patient or the patient's HCR	• Signed by the patient and their HCR

Having a Good Conversation About Your Treatment Options

You cannot complete the form on your own. You will need to have a conversation with your health care professional about your treatment options. This will include talking about difficult topics, including dying. Make sure you talk frankly with your health care professional about the end-of-life treatments you want or don't want, and how likely treatments are to work for you.

Having an in-depth conversation about your treatment options will better ensure that your health care provider and loved ones understand your wishes. The POLST Form provides a framework for having and documenting this important conversation.

Who Completes and Signs the POLST Form?

If you are able to communicate for yourself, you can complete the POLST Form with your health care professional. If you are unable to speak for yourself, your health care representative can complete a POLST Form on your behalf. Because the POLST Form contains medical orders, it must be signed by a physician, nurse practitioner or physician assistant.

Who Can Speak for Me if I Can No Longer Communicate?

If you are unable to communicate, someone else may be able to complete a POLST Form with your health care professional on your behalf. An Oregon Advance Directive is a way to communicate your wishes if you can no longer speak for yourself.

Oregon's Advance Directive allows you to legally appoint a Health Care Representative. This is a person you choose to represent you to advocate for your wishes if you are unable to speak for yourself.

Who Can Be My Health Care Representative in My Advance Directive?

You should choose the person you feel the most comfortable with to make medical decisions that honor your wishes. This person must be at least 18 years of age. You may not choose your doctor, an employee of your doctor, or an owner, operator of your health care facility—unless that person is related to you by blood, marriage or adoption, or that person was appointed before your admission into the health care facility.

Without a Health Care Representative, Who Can Represent You?

Oregon provides a list of surrogate decision makers to represent you if you are determined to be near the end of your life. For other situations, Oregon law does not say who should represent you, however most facilities use the same list:

(a) A guardian who is authorized to make health care decisions, if any;
(b) Your spouse or registered domestic partner;
(c) An adult designated by the others listed here who can be so located, if no person listed here objects to the designation;
(d) A majority of your adult children;
(e) Either of your parents;
(f) A majority of your adult siblings who can be located with reasonable effort; or
(g) Any adult relative or adult friend.

To choose who represents you if you can't speak for yourself, you should complete an Advance Directive.

Should I Sign the POLST Form Too?

If you are able to communicate your wishes in a POLST Form, we **strongly recommend** that you sign the form and discuss opting in or out of the Registry. Your signature helps show you were part of the conversation and agree with the orders on your POLST Form.

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: ☐

From Section E of the Oregon POLST Form

Where do I keep my POLST Form?

Once signed, a copy of the POLST Form will become part of your medical record.

- If you are at home, place the Form **on** (not **in**!) your refrigerator or in your medicine cabinet.
- If your POLST Form is in the POLST Registry, put the registry magnet on your refrigerator and;
- Place a POLST Registry sticker in your wallet, purse, or billfold.
- If you are in a hospital, nursing home, or assisted living facility, it will be in your chart or file. If you go to a medical facility or hospital bring your POLST Form with you.

As of 2014, the Oregon POLST Task Force no longer provides wallet cards. EMS does not look through a person's wallet during an emergency.

POLST Registry magnet

"You can really lift a burden from those you love by completing an Advance Directive and having a health care professional fill out and sign a POLST Form when you are seriously ill. It gives you reassurance that you will receive the treatments you want and avoid the treatments you do not want."

-Doctor Patra Behary, Oregon POLST Task Force Vice Chair

What Happens in an Emergency?

To ensure that your POLST Form is found and known in a time of emergency, your information is entered into the Oregon POLST Registry—unless you choose not to participate and have checked the opt-out box on the form.

The POLST Registry is a secure database of Oregon POLST Forms that allows emergency staff to access your information quickly in a crisis. It provides a backup to the paper form when the form cannot be immediately found. Emergency personnel, emergency departments, and intensive care units have 24-hour access to the POLST Registry to check if you have a POLST Form. Unless you opt out, your POLST Form will be included in the Oregon POLST Registry.

When your POLST Form is entered into the Oregon POLST Registry you will receive a letter, a magnet, and a sticker with a special Registry identification number. Put the POLST magnet on your refrigerator to alert EMS that you have a POLST Form.

Only POLST Forms signed by an Oregon Health Care Professional can be entered into the Registry. More resources and information are available at the Oregon POLST Registry's website: www.orpolstregistry.org.

What if I Change My Mind?

POLST records your wishes for medical treatment now, in your *current* state of health. If your wishes change, talk with your health care professional as soon as possible so that a new POLST can be completed and filed with the registry.

Your POLST should be reviewed when:

- You are transferred from one care setting or care level to another, or
- There is a substantial change in your health status, or
- Your treatment preferences change.

POLST: What the Treatment Options Mean

The POLST Form lists some of the medical treatments you can choose to have or not have. Your health care professional can help you decide which options will best help you reach the goals you have for your care. The POLST Form also directs initial treatment in an emergency. Treatments once started can be continued, changed or discontinued once more is known about your medical condition.

Section A

A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR):** ***Unresponsive, pulseless, & not breathing.***
	Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR If patient is not in cardiopulmonary arrest, follow orders in B and C.

From Section A of the Oregon POSLT Form

Section A of the POLST Form is about resuscitation and directs paramedics and EMTs about whether to attempt resuscitation when your heart stops and you stop breathing. In making a decision on what you want for this section of the form, it is important to have a frank discussion with your health care provider about how effective cardio pulmonary resuscitation (CPR) is likely to be for you.

For people with serious illness and frailty CPR is likely to be ineffective. CPR is successful for less than 3% of frail nursing home residents. Most patients who have enrolled in hospice or who are receiving long-term nursing care choose the option 'do not attempt resuscitation,' also known as a DNR order.

It's important for you to understand what each of these options mean, so make sure you talk to your health care provider before you make any decisions. You can then choose what treatment options you prefer.

Cardiopulmonary Resuscitation (CPR)
An emergency procedure to try to make the heart and lungs work by manually compressing the chest and shocking the heart.

DNR
Do Not Resuscitate (or DNR) is a medical order not to try cardiopulmonary resuscitation (CPR).

Section B

B *Check One*	**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 fluidsand 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. ***Transferto hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: All treatments including breathing machine.** ***Additional Orders:***_____

From Section B of the Oregon POLST Form

The decisions made in Section B of the POLST are VERY important in guiding the direction of your treatment. Your goal may be to focus solely on comfort care, or on limited treatments that are likely to restore you to your current health, or on full life-sustaining treatments in the hospital's Intensive Care Unit (ICU).

Section B allows you to let your health care professionals know what type of care and treatment you do or do not want, such as a breathing machine. If you are without a POLST Form you will receive full treatment, including life-sustaining measures in the ICU. Regardless of which level of treatment you select, comfort care will always be provided.

Comfort Measures Only
Choose this if you want the focus of your care to be maximizing your comfort and avoiding hospitalizations unless necessary to ensure comfort needs are met. Comfort measures are meant to make you feel comfortable and reduce your pain. They are not meant to make you live longer. A person who requests "comfort measures only" on their POLST Form would be transferred to the hospital only if his or her comfort needs could not be met in the current location.

Limited Treatment
Choose this if you would like to return to the hospital for basic medical treatments such as antibiotics for infections or intravenous fluids for dehydration. People who opt for this choice generally wish to avoid the ICU and do not want to be put on a breathing machine.

Full Treatment
Choose this if you would like full treatment with the hope of sustaining life, including use of a breathing machine and other treatments in an ICU.

Tube Feeding
This is a way of feeding a person through a tube either in his/her nose or directly through the skin into his/her stomach.

Section C

C *Check One*	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.	***Additional Orders (e.g. defining the length of a trial period):*** _____ _____

From Section C of the Oregon POLST Form

Oregon law presumes that you would want artificial nutrition unless you have indicated otherwise. You can use the POLST Form to document whether you would or would not want artificial nutrition.

Food and fluids are always offered by mouth when feasible. Some patients would prefer long-term artificial nutrition by tube. Studies have shown that for patients with some conditions (for example those with permanent coma) artificial nutrition by tube can lengthen lives. However, for patients with advanced cancer or Alzheimer's dementia tube feeding may not lengthen life.

Others may want to try a feeding tube for awhile. For example, if you suffer a stroke and have difficulty swallowing, you may choose a feeding tube to see if you can recover.

Section D

D *Must Fill Out*	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 devlopmental disabilities or significant mental health condition (Note:Special requirements for completeion- see reverse side) Representative/Surrogate Name:_____Relationship: _____

From Section D of the Oregon POLST Form

Your physician must document with whom they discussed the POLST orders.

Section E

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: ☐

From Section E of the Oregon POLST Form

The Oregon POLST Task Force strongly recommends that you or your surrogate sign the POLST Form, as it provides tangible evidence that the conversation occurred and that the form's orders are consistent with your wishes.

Section F

F *Must Print Name, Sign & Date*	ATTESTATION OF MD/DO/NP/PA (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***	Signer Phone Number:	Signer License Number:(optional)
	MD/DO/NO/PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

From Section F of the Oregon POLST Form

The POLST Form turns your wishes into action with medical orders signed by your physician, nurse practitioner, or physician's assistant.

Side 2 of the POLST Form

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 advanced 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. However, no form 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:			

Side 2 of the POLST Form contains additional information (a short review about what you've learned about POLST). Note the reminder that you update your Advance Directive when you have a POLST (you want to make sure they do not conflict with each other!) **and** give a copy of your Advance Directive to your health care professional. This helps them know who your health care representative is in case you cannot speak for yourself.

The Contact Information is also helpful. This is **not** a place for you to designate an individual as his/her health care representative- that can only be done through an Advance Directive- but a place to put who your health care representative is along with how they can be reached.

Final Key Points about POLST:

- **POLST is always voluntary** and intended for people with serious illness and/or frailty.
- The POLST treatment plan should reflect the patient's wishes now in their **current** state of health and **not** future wishes for when their health may have deteriorated. The POLST should represent what treatments you would want if you were to become ill tonight. Future wishes, if different than current wishes, are best documented on an Advance Directive.
- The POLST guides initial medical treatment and the plan of care, and can be changed if patient wishes and goals change when more medical information is available.

Your Treatment Wishes Checklist

☐ Talk about your treatment wishes with your loved ones.

☐ Complete an Advance Directive and give a copy to your Health Care Representative and your health care professional.

☐ Talk about your treatment wishes with your health care professional.

☐ If you have serious illness or are frail consider completing a POLST Form with your health care professional to reflect your treatment wishes in your current state of health.

☐ Post a copy of your form or your POLST Registry magnet on your refrigerator and bring a copy of the form with you to the hospital or health care facility.

☐ When your treatment wishes change, create a new POLST Form with your health care professional.

For more information:

Ask your doctor, nurse practitioner or physician assistant
or visit www.or.polst.org

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