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

Montana Provider Orders For Life-Sustaining Treatment (POLST)

THIS FORM MUST BE SIGNED BY A ***PHYSICIAN, PA*** *or* ***APRN*** *IN SECTION E TO BE VALID*

If any section is NOT COMPLETE:

Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male ☐ Female ☐

Section A

Select only one box

Cardiopulmonary Resuscitation: If patient does not have a pulse and/or is not breathing:

☐ **Resuscitate (Full Code)**

☐ **Do Not Resuscitate (No Code)**
(Allow Natural Death)(Comfort One)
Patient does not want any heroic or Life-saving measures.

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

Section B

Select only one box

Medical Interventions: If patient has a pulse and/or is breathing:

☐ **Comfort Measures:** Please treat patient with dignity and respect. Reasonable measures are to be made to offer food and fluids by mouth and attention must be paid to hygiene. Medication, positioning, wound care, and other measures shall be used to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **EMS**: Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.

☐ **Limited Additional Interventions:** In addition to the care described above, cardiac monitoring and oral/IV medications may be provided. **EMS:** Transfer to hospital if indicated, do not perform intubation or advanced airway interventions. **Hospital:** Do not admit to Intensive Care.

☐ **Full Treatment:** In addition to the care described above, endotracheal intubation, advanced airway interventions, mechanical ventilation, defibrillation and cardioversion may be provided. **Hospital:** Admit to Intensive Care if indicated.

Other Instructions:

Section C

May select more than one

Artificial Fluids and Nutrition:
☐ Feeding tube ☐ No Feeding tube
☐ IV fluid ☐ No IV fluid
Other Instructions:

Antibiotics and Blood Products:
☐ Antibiotics ☐ No Antibiotics
☐ Blood Products ☐ No Blood Products
Other Instructions:

Section D

Advance Directives: The following documents also exist:
☐ Living Will ☐ Other _____

_____

Section E

Patient or **Surrogate Signature:** _____ Date:_____
(by signing the POLST, I agree that this POLST supersedes my living will, if the two conflict)

Print Patient or Surrogate *(person with authority under 50-9-106, MCA)*

Name:_____ Relationship:_____

Physician/ APRN/ PA *(in consultation with supervising physician)* **Signature:** _____ Date:_____

Print Physician/APRN/PA Name : _____ MT License Number: _____

Contact Phone Number: _____ **Discussed with:** ☐ Patient ☐ Spouse ☐ Other _____

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference _____

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid

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Instructions for completing the POLST form:

1. **PRINT (form must be readable)**
2. **EMS instructions are contained in sections A & B**
3. **Facility instructions are primarily contained in sections B & C**
4. **To be VALID section E must be completed**

POLST/ DNR Protocol:

The POLST form helps assure that patient wishes to have or limit specific medical treatments are respected near the end of life by all providers. The POLST can include a DNR order.

Before issuing POLST, Montana licensed Physicians/APRNs/PAs should always consider:

Diagnoses and consultation with patient (if unable to consult with patient consider known history and medical records), determine if the patient has advance directives or living will, consult with family to determine if the patient expressed his/her wishes, determine the patient is in a terminal condition, and consult the "end of life registry" at www.endoflife.mt.gov. Make completed form clearly visible to providers.

The provider should review the POLST form in all of the following instances:

- each time a patient is admitted to a facility,
- any time there is a substantial change in the patient's health status, or
- any time the patient's treatment preferences change.

Out-of-Hospital Protocol when presented with POLST Documentation:

Never delay patient care to determine if the patient has POLST documentation. COMFORT One bracelet identifies a patient who has a POLST document and a DNR (section A). A verbal DNR order from a physician must be honored.

POLST documentation, if presented to the out-of-hospital provider, MUST accompany the patient and be presented to other health care providers who subsequently attend the patient. The out-of-hospital patient care documentation must include the POLST documentation and care provided based on the POLST documentation.

A POLST document can be disregarded if the patient requests or if the terminal condition no longer exists. If there is a question regarding POLST, contact Medical Control.

Health care provider responsibilities when presented with POLST Documentation:

If POLST documentation accompanies the patient, all health care providers must honor the patient's wishes. The POLST documentation expresses the patient's treatment wishes in advance of a medical emergency. A valid POLST documentation is a Montana standardized form that has a valid physician, APRN or PA signature. The form presented may be a photocopy, fax or electronic copy but must have a valid signature.

The POLST documentation must accompany the patient if care is transferred to another provider or facility.

A POLST document can be disregarded if the patient or surrogate (who signed the form) requests or if the terminal condition no longer exists, or if there is a direct order from a physician or APRN or PA.

Questions please consult the website for information: http:// polst.mt.gov

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