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

Treatment Options: If patient does not have a pulse and is not breathing:

☐ **Resuscitate (CPR)**

☐ **Do Not Resuscitate (DNR/No CPR)**
(Allow Natural Death)

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

Section B
Select only one box

Treatment Options: If patient has a pulse and/or is breathing:

☐ **Comfort Measures:** Treat patient with dignity and respect. Keep patient clean, warm and dry. Reasonable measures are to be made to offer food and fluids by mouth. Use medication, positioning, wound care and other measures to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **DO NOT transfer to hospital for life-sustaining treatment. Transfer ONLY if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions:** In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. ***Transfer to hospital if indicated. Avoid Intensive Care.***

☐ **Full Treatment:** In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. ***Transfer to hospital if indicated. Include Intensive Care.***

Other Instructions: _____
_____

Section C
Select only one box

Antibiotics:

☐ No antibiotics except if needed for comfort (i.e. urinary tract infection)

☐ No Invasive **(IM/IV)** antibiotics

☐ Aggressive treatment **Other instructions:** _____

Section D
Select only one box

Medically Administered Nutrition:

☐ No Feeding tube

☐ Feeding tube for defined trial period

☐ Feeding tube long-term **Other Instructions:** _____

Section E

Discussed with: ☐ Patient/Resident ☐ Healthcare Agent/Surrogate ☐ Court appointed Guardian

☐ Other _____

Name of Agent/Surrogate/Guardian/Other: _____
Phone #: _____

The basis for these orders is: ☐ Patient's preference ☐ Patient's best interest

☐ Other _____

Signature of Physician/Nurse Practitioner/Physician Assistant (mandatory)	**Physician/NP/PA Name (type or print)**	**Time and Date**

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

Section F

Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POLST Form

I have given significant thought to life-sustaining treatment. I have expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following have further information regarding my preferences.

Advance Directive ☐ NO ☐ YES

Court-appointed Guardian ☐ NO ☐ YES

Review and discuss these orders if there is substantial change in my health status, such as:

Advanced progressive illness Close to death Extraordinary suffering
Improved condition Permanent unconsciousness

Signature of Patient/Resident, Parent of minor or Guardian/Healthcare Agent (optional)

Signature of Person preparing form	**Preparer Name (please print)**	**Date form prepared**

Section G

Review of this POLST Form

Date	**Reviewer**	**Location of Review**	**Outcome of Review**
SAMPLE			☐ **No change** ☐ **FORM VOIDED, new form completed** ☐ **FORM VOIDED, *no* new form**
			☐ **No change** ☐ **FORM VOIDED, new form completed** ☐ **FORM VOIDED, *no* new form**
			☐ **No change** ☐ **FORM VOIDED, new form completed** ☐ **FORM VOIDED, *no* new form**
			☐ **No change** ☐ **FORM VOIDED, new form completed** ☐ **FORM VOIDED, *no* new form**

COMMENTS:

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Updated: 7/1/11