

**Revised California POLST Form – Summary of Changes  
Effective April 1, 2011**



**Background**

The current California POLST form (Physician Orders for Life-Sustaining Treatment) went into effect January 1, 2009. At the recommendation of the National POLST Task Force, the California POLST Task Force reviews the California POLST form every two years and recommends changes, in response to feedback based on actual usage of the form in the field.

The POLST Task Force created a Documentation Committee to process and make recommendations on the more than 250 suggested changes received from healthcare providers, consumer advocates, and others. The Committee's recommendations were reviewed and approved by the full POLST Task Force, and later by the California Emergency Medical Services Authority (EMSA) Commission.

**Guiding Principle**

In reviewing the suggested changes, the Documentation Committee held to the guiding principle that any recommended change needed to provide significant or substantial improvement or clarification to the POLST form. In addition, two key considerations were to (1) maintain California's POLST form as a one-page, two-sided document, and (2) keep all the critical information on the front of the form for ease of reference.

**General Changes**

The standard color of California's POLST form has changed from Pulsar Pink to Ultra Pink (still on 65# cardstock). Some copy and fax machines have not been able to duplicate forms printed on Pulsar Pink legibly. Ultra Pink was tested to confirm a better result on a wider range of copiers and fax machines.

Throughout the POLST form, the term health care 'professional' was changed to health care 'provider' to be consistent with language in the POLST law.


**Things to Remember**

A few key points to keep in mind:


- Previously completed POLST forms remain valid
- Best practice suggests using the revised 2011 POLST form beginning April 1, 2011, rather than trying to 'use up' old POLST form supplies
- POLST forms are valid regardless of the color paper used
- Copies and faxes of POLST forms are as valid as the original

**Section-by-Section Revisions with Rationale**

**2011 POLST FORM – HEADER**

<b>HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY</b>								
 <p>EMSA #111 B (Effective 4/1/2011)</p>	<b>Physician Orders for Life-Sustaining Treatment (POLST)</b>							
	<p>First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.</p>	<table border="1"> <tr> <td>Patient Last Name:</td> <td>Date Form Prepared:</td> </tr> <tr> <td>Patient First Name:</td> <td>Patient Date of Birth:</td> </tr> <tr> <td>Patient Middle Name:</td> <td>Medical Record #: <i>(optional)</i></td> </tr> </table>	Patient Last Name:	Date Form Prepared:	Patient First Name:	Patient Date of Birth:	Patient Middle Name:	Medical Record #: <i>(optional)</i>
	Patient Last Name:	Date Form Prepared:						
	Patient First Name:	Patient Date of Birth:						
Patient Middle Name:	Medical Record #: <i>(optional)</i>							

**OLD POLST FORM**

<b>HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY</b>								
 <p>EMSA #111 B (Effective 1/1/2009)</p>	<b>Physician Orders for Life-Sustaining Treatment (POLST)</b>							
	<p>First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.</p>	<table border="1"> <tr> <td colspan="2">Last Name</td> </tr> <tr> <td colspan="2">First /Middle Name</td> </tr> <tr> <td>Date of Birth</td> <td>Date Form Prepared</td> </tr> </table>	Last Name		First /Middle Name		Date of Birth	Date Form Prepared
	Last Name							
	First /Middle Name							
Date of Birth	Date Form Prepared							

<b>Change/Addition/Deletion:</b>	<b>Rationale:</b>
1. Changed effective date (under EMSA logo) from 1/1/2009 to 4/1/2011.	This designates the version and effective date of the form.
2. Added sentence to introductory paragraph – “A copy of the original POLST form is legal and valid.”	This emphasizes to providers who are acting on the form that a copy of the POLST form is valid. There are additional instructions about copies and faxes on the back of the form, but adding this sentence here gives more prominence to the validity of copies.
3. Added sentence to introductory paragraph – “POLST complements an Advance Directive and is not intended to replace that document.”	There is confusion among providers about whether POLST replaces the Advance Directive. Adding this sentence conveys a relationship between POLST and the Advance Directive. Additional instructions were also added to the back of the form regarding reviewing Advance Directives and POLST to ensure agreement between the two forms.
4. Added the word “patient” to the demographic information on the top right of the form.	This clarifies that it is the patient’s name and date of birth that are to be filled in.
5. Added “Medical Record # <i>(optional)</i> ” to the top right of the form. This replaces the previous “Office Use Only” box that was on the bottom right corner of the previous POLST form.	A survey of healthcare providers using POLST forms identified that the “Office Use Only” box was being used infrequently, primarily to list the patient’s medical record number. For consistency with other medical forms, Medical Record # was added to the upper right corner along with the other patient demographic information. It is also noted that Medical Record # is “optional” as a patient’s number may vary by setting.

**2011 POLST FORM – SECTION A**

<b>A</b> <i>Check One</i>	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A <u>requires</u> selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR ( <u>A</u> llow <u>N</u> atural <u>D</u> eath)

**OLD POLST FORM**

<b>A</b> <i>Check One</i>	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>Person has no pulse and is not breathing.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR (Section B: Full Treatment required) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR ( <u>A</u> llow <u>N</u> atural <u>D</u> eath)
<i>When not in cardiopulmonary arrest, follow orders in B and C.</i>	

Change/Addition/Deletion:	Reason:
6. Added formatting and the word “If” to the phrase, “Person has no pulse and is not breathing.” Also moved “When NOT in cardiopulmonary arrest, follow orders in Sections B and C” to be in the heading.	Helps clarify when Section A is to be followed.
7. Changed the statement following Attempt Resuscitation/CPR from “Section B: Full Treatment required” to “Selecting CPR in Section A <u>requires</u> selecting Full Treatment in Section B.”	Helps clarify the requirement that Full Treatment be selected with CPR.
8. Changed formatting of the options from a horizontal orientation to a vertical orientation.	Makes Section A consistent with formatting of Section B and easier to follow.

2011 POLST FORM – SECTION B

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS:</b> <span style="float: right;"><i>If person has pulse and/or is breathing.</i></span>
	<input type="checkbox"/> <b>Comfort Measures Only</b> Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Transfer to hospital <u>only</u> if comfort needs cannot be met in current location.</i> <input type="checkbox"/> <b>Limited Additional Interventions</b> In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> <i>Transfer to hospital <u>only</u> if comfort needs cannot be met in current location.</i> <input type="checkbox"/> <b>Full Treatment</b> In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i> Additional Orders: _____ _____

OLD POLST FORM

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS:</b> <span style="float: right;"><i>Person has pulse and/or is breathing.</i></span>
	<input type="checkbox"/> <b>Comfort Measures Only</b> Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. <b>Transfer</b> if comfort needs cannot be met in current location. <input type="checkbox"/> <b>Limited Additional Interventions</b> Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> <b>Do Not Transfer to hospital for medical interventions.</b> <b>Transfer</b> if comfort needs cannot be met in current location. <input type="checkbox"/> <b>Full Treatment</b> Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <b>Transfer</b> to hospital if indicated. <i>Includes intensive care.</i> Additional Orders: _____ _____

**Change/Addition/Deletion:**

9. Added formatting and the word "If" to the phrase, "Person has pulse and/or is breathing."

**Reason:**

Helps clarify when Section B is to be followed.

<b>Change/Addition/Deletion:</b>	<b>Reason:</b>
<b><i>Comfort Measures Only</i></b>	
10. Changed the description of Comfort Measures Only from “Use medications by any route, positioning, wound care and other measures to relieve pain and suffering.” to “Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures.	Emphasizes the goal of Comfort Measures Only – to relieve pain and suffering.
11. Deleted statement in description of Comfort Measures Only “Antibiotics only to promote comfort.”	There has been confusion about the subjectivity of this statement. Additional instructions were added to the back of the form to better address antibiotics and Comfort Measures Only.
12. Changed transfer language in Comfort Measures Only to “Transfer to hospital <u>only</u> if comfort needs cannot be met in current location.”	Helps clarify when to transfer a patient who has selected Comfort Measures Only.
<b><i>Limited Additional Interventions</i></b>	
13. Changed description of Limited Additional Interventions from “Includes care described above.” to “In addition to care described in Comfort Measures Only, use...”	Clarifies the term “care described above.”
14. Changed transfer language in Limited Additional Interventions to “Transfer to hospital <u>only</u> if comfort needs cannot be met in current location.”	Helps clarify when to transfer a patient who has selected Limited Additional Interventions.
<b><i>Full Treatment</i></b>	
15. Changed description of Full Treatment from “Includes care described above” to “In addition to care described in Comfort Measures Only and Limited Additional Interventions, use...”	Clarifies term “care described above.”

**2011 POLST FORM – SECTION C**

<b>C</b> <i>Check One</i>	<b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food by mouth if feasible and desired.</i>	
	<input type="checkbox"/> No artificial means of nutrition, including feeding tubes. Additional Orders: _____	_____
	<input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____	_____
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. _____	_____

**OLD POLST FORM**

<b>C</b> <i>Check One</i>	<b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food by mouth if feasible and desired.</i>	
	<input type="checkbox"/> No artificial nutrition by tube.	<input type="checkbox"/> Defined trial period of artificial nutrition by tube.
	<input type="checkbox"/> Long-term artificial nutrition by tube.	
	Additional Orders: _____	

Change/Addition/Deletion:	Reason:
16. Changed the phrase, used in all options, “by tube” to “including feeding tubes.”	Clarifies that total parenteral nutrition (TPN) is included.
17. Deleted “Defined” from “Trial period”	Needed space on the form and the word did not add significant clarity.
18. Changed formatting of the options from a horizontal orientation to a vertical orientation.	Makes Section C consistent with formatting of Sections A and B and easier to follow.

**2011 POLST FORM – SECTION D**

<b>D</b>	<b>INFORMATION AND SIGNATURES:</b>		
	Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker		
	<input type="checkbox"/> Advance Directive dated _____ available and reviewed →		Health Care Agent if named in Advance Directive:
	<input type="checkbox"/> Advance Directive not available		Name: _____
	<input type="checkbox"/> No Advance Directive		Phone: _____
	<b>Signature of Physician</b>		
	My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.		
	Print Physician Name:	Physician Phone Number:	Physician License Number:
	Physician Signature: <i>(required)</i>		Date:
	<b>Signature of Patient or Legally Recognized Decisionmaker</b>		
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.			
Print Name:		Relationship: <i>(write self if patient)</i>	
Signature: <i>(required)</i>		Date:	
Address:	Daytime Phone Number:	Evening Phone Number:	
<b>SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED</b>			

**OLD POLST FORM**

<b>D</b>	<b>SIGNATURES AND SUMMARY OF MEDICAL CONDITION:</b>		
	Discussed with:		
	<input type="checkbox"/> Patient <input type="checkbox"/> Health Care Decisionmaker <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court Appointed Conservator <input type="checkbox"/> Other:		
	<b>Signature of Physician</b>		
	My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.		
	Print Physician Name	Physician Phone Number	Date
	Physician Signature (required)		Physician License #
	<b>Signature of Patient, Decisionmaker, Parent of Minor or Conservator</b>		
	By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.		
	Signature (required)	Name (print)	Relationship (write self if patient)
Summary of Medical Condition		Office Use Only	
<b>SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED</b>			

Change/Addition/Deletion:	Reason:
19. Changed heading from “Signatures and Summary of Medical Condition” to “Information and Signatures.”	Accurately reflects revised information in Section D.
20. Changed check-box options for “Discussed with” (from “Patient,” “Health Care Decisionmaker,” “Parent of Minor,” “Court Appointed Conservator” or “Other”) to “Patient (Patient Has Capacity)” or “Legally Recognized Decisionmaker.”	Many suggestions indicated that the original terms used were confusing. Using “Patient” or “Legally Recognized Decisionmaker” is consistent with the language used in California’s POLST law. There were several suggestions to include an indication that the patient had decisionmaking capacity.
21. Added check boxes for “Advance Directive dated _____ available and reviewed,” “Advance Directive not available,” and “No Advance Directive.”	Highlights the importance of asking for and reviewing a patient’s Advance Directive.
22. Added a section to document the name and contact information of the Health Care Agent appointed in an Advance Directive.	This information is very valuable reference information for providers.
23. Changed heading of Patient/Decisionmaker signature from “Signature of Patient, Decisionmaker, Parent of Minor or Conservator” to “Signature of Patient or Legally Recognized Decisionmaker.”	Makes language consistent with other changes in Section D and with California’s POLST law.
24. Added “Date” to Patient or Legally Recognized Decisionmaker signature.	Clarifies when the patient or decisionmaker signed the form.
25. Moved address for Patient or Legally Recognized Decisionmaker signatory from the back to the front of the form. Added “Daytime Phone Number” and “Evening Phone Number” for patient or decisionmaker signatory.	Makes important contact information more easily referenced for health care providers.
26. Deleted “Summary of Medical Condition”	Needed space, and this information is not as significant as new information added to Section D.



**2011 POLST FORM – CONTACT INFORMATION (BACK SIDE)**

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
<b>Patient Information</b>		
Name (last, first, middle):	Date of Birth:	Gender: M F
<b>Health Care Provider Assisting with Form Preparation</b>		
Name:	Title:	Phone Number:
<b>Additional Contact</b>		
Name:	Relationship to Patient:	Phone Number:

**OLD POLST FORM**

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		
Patient Name (last, first, middle)	Date of Birth	Gender: M F
Patient Address		
<b>Contact Information</b>		
Health Care Decisionmaker	Address	Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number
		Date Prepared

<b>Change/Addition/Deletion:</b>	<b>Reason:</b>
27. Added heading, "Patient Information."	Makes consistent with the rest of the formatting.
28. Changed heading to "Health Care Provider Assisting with Form Preparation."	Provides clarification on the health care provider's role.
29. Added section for "Additional Contact" including "Name," "Relationship to Patient," and "Phone Number."	If the decisionmaker is not the signor of the form, then decisionmaker's contact can be captured here. If decisionmaker is the signor, then another contact person can be listed here.

## 2011 POLST FORM – DIRECTIONS (BACK SIDE)

### Directions for Health Care Provider

#### Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

#### Using POLST

- Any incomplete section of POLST implies full treatment for that section.

##### Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

##### Section B:

- 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).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

#### Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

#### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.  
For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

Change/Addition/Deletion:	Reason:
<b>Directions – Completing POLST</b>	
30. Added bullet, “Completing a POLST form is voluntary. California law requires that the orders in a POLST form be followed by health care providers, and provides immunity to those who comply in good faith with a patient’s POLST wishes. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.”	Includes important information consistent with California’s POLST law and hospital regulations.
31. Added bullet, “POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.”	Clarifies that POLST complements an Advance Directive. Highlights the importance of comparing a patient’s forms (POLST and Advance Directive) for consistency.
32. Added bullet, “A Legally Recognized Decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient’s physician believes best knows what is in the patient’s best interest and will make decisions in accordance with the patient’s expressed wishes and values to the extent known.”	Because “Legally Recognized Decisionmaker” is not defined in statute, provides a description in a manner consistent with California law and practices.
33. Changed phrase in bullet regarding RCFEs from “medical conditions or medical treatments” to “medical conditions or treatments.”	Needed the space on the form and deleting repetitive adjective did not change the meaning of the sentence.
34. Added bullet, “If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.”	Several translations of the POLST form are currently available. These instructions clarify what to do with the translated form and reinforces to providers that the English version of the form is to be signed.
35. Added statement to last bullet, “A copy should be retained in patient’s medical record, on Ultra Pink paper when possible.”	Provides direction for providers about keeping a copy of the POLST form, and encourages use of Ultra Pink paper for those copies.

Change/Addition/Deletion:	Reason:
<b>Directions – Using POLST</b>	
36. Changed bullet with instructions regarding Section A from “No defibrillator (including automated external defibrillators) should be used on a person who has chosen ‘Do Not Attempt Resuscitation’” to “If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen ‘Do Not Attempt Resuscitation.’”	These additional instructions attempt to address concerns expressed about patients who select DNR and Full Treatment.
37. Changed bullet with instructions regarding Section B from “IV medication to enhance comfort may be appropriate for a person who has chosen ‘Comfort Measures Only’” to “IV antibiotics and hydration generally are not ‘Comfort Measures.’”	There has been confusion about the subjectivity of when antibiotics are used for someone who has chosen Comfort Measures Only. These revised instructions attempt to provide more clarity that antibiotics generally are not appropriate for patients choosing Comfort Measures Only.
38. Changed bullet with instructions regarding Section B from “A person who desires IV fluids should indicate ‘Limited Interventions’ or ‘Full Treatment’” to “If person desires IV fluids, indicate ‘Limited Interventions’ or ‘Full Treatment.’”	Needed space on the form and revising this statement to shorten it did not change its meaning.
39. Added bullet “Depending on local EMS protocol, “Additional Orders” written in Section B may not be implemented by EMS personnel.”	There has been some concern that EMS may not be able to review and act upon Additional Orders written in Section B.
<b>Directions – Modifying and Voiding POLST</b>	
40. Changed bullet from “A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form” to “A patient with capacity can, at any time, request alternative treatment.”	Separates patient’s right to request for alternative treatment from patient’s right to revoke form. Makes language consistent with California’s POLST law.
41. Changed bullet from “To void POLST, draw a line through Section A through D and write ‘VOID’ in large letters. Sign and date this line” to “A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing ‘VOID’ in large letters, and signing and dating this line.”	Separates patient’s right to request for alternative treatment from patient’s right to revoke form. Makes language consistent with California’s POLST law.
42. Changed bullet from “a health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual’s best interests.” to “A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual’s best interests.”	Clarifies that the surrogate cannot unilaterally change a POLST form. Uses language consistent with California’s POLST law.