HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

Follow these orders until orders are reviewed. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	Middle Int.

Date of Birth: (mm/dd/yyyy)	Gender	Last 4 SSN:
____ ____ ____	☐ M ☐ F	☐☐☐☐

If the patient has decision-making capacity, the patient's presently expressed wishes should guide his or her treatment

A — CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

Check One

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in B and C.

B — MEDICAL INTERVENTIONS: If patient has pulse and is breathing.

Check One

☐ **Full Treatment – goal is to prolong life by all medically effective means.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and /or intensive care unit if indicated.
Care Plan: Full treatment including life support measures in the intensive care unit.

☐ **Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures**
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.**
Care Plan: Provide basic medical treatments.

☐ **Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering**
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. Consider hospice or palliative care referral if appropriate.**
Care Plan: Maximize comfort through symptom management.

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.

Check One

☐ **Long-term artificial nutrition by tube**.

☐ **Defined trial period of artificial nutrition by tube.**

☐ **No artificial nutrition by tube.**

Additional Instructions: _____

D — HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate

Check One

☐Patient/Resident Currently enrolled in Hospice Care Contact: _____	☐Patient/Resident Currently enrolled in Palliative Care Contact: _____	☐Not indicated or refused

SIGNATURES

Print Physician Name	MD/DO License #	Phone Number
Physician Signature **(mandatory)**	Date	
Print Patient/Resident or Surrogate/Proxy Name	Relationship (write 'self' if patient)	
Patient or Surrogate Signature **(mandatory)**	Date	

SEND FORM WITH PATIENT WHENEVER TRANFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST are legal and valid.

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

E Check All That Apply

DOCUMENTATION OF DISCUSSION:

☐Patient (Patient has capacity) ☐Health Care Representative or surrogate

☐Parent of minor ☐Court-Appointed Guardian ☐Other (proxy)

Other Contact Information

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number/Address	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POLST

- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- 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, such as a hospice unit.
- A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

To void this form, draw line through sections A through D on page 1 and write "VOID" in large letters.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED