2011 California POLST Form

Effective April 1, 2011

In order to maintain continuity throughout California, please follow these instructions:

*** Copy or print POLST form on 65# Cover Ultra Pink card stock. ***

Mohawk BriteHue Ultra Pink card stock is available online and at some retailers, such as FedEx/Kinko’s.

Ultra Pink paper is used to distinguish the form from other forms in the patient’s record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.
A  
**CARDIOPULMONARY RESUSCITATION (CPR):**  If person has no pulse and is not breathing.

When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- [ ] Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- [ ] Do Not Attempt Resuscitation/DNR  (Allow Natural Death)

B  
**MEDICAL INTERVENTIONS:**  If person has pulse and/or is breathing.

- [ ] Comfort Measures Only  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.  *Transfer to hospital only* if comfort needs cannot be met in current location.
- [ ] Limited Additional Interventions  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.
  - [ ] Transfer to hospital only  if comfort needs cannot be met in current location.
- [ ] Full Treatment  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.  *Transfer to hospital if indicated.*  *Includes intensive care.*

Additional Orders:

C  
**ARTIFICIALLY ADMINISTERED NUTRITION:**  Offer food by mouth if feasible and desired.

- [ ] No artificial means of nutrition, including feeding tubes.  Additional Orders: _________________________
- [ ] Trial period of artificial nutrition, including feeding tubes.  Additional Orders: _________________________
- [ ] Long-term artificial nutrition, including feeding tubes.  Additional Orders: _________________________

D  
**INFORMATION AND SIGNATURES:**

Discussed with:  
- [ ] Patient  (Patient Has Capacity)
- [ ] Legally Recognized Decisionmaker

- [ ] Advance Directive dated __________ available and reviewed  
  Health Care Agent if named in Advance Directive:
  Name: _________________________________________
  Phone: _________________________________________
- [ ] Advance Directive not available
- [ ] No Advance Directive

**Signature of Physician**

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 Signature: (required)

Physician Phone Number: _________________________

Physician License Number: _________________________

Date: _________________________

**Signature of Patient or Legally Recognized Decisionmaker**

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: (write self if patient)

Signature: (required)

Date: _________________________

Address: _________________________

Daytime Phone Number: _________________________

Evening Phone Number: _________________________

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**

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<tr>
<th>Patient Information</th>
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<td>Name (last, first, middle):</td>
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<th>Health Care Provider Assisting with Form Preparation</th>
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**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**