

## California POLST Form

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

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

Wausau Pulsar Pink card stock is available online and at some office supply stores.

Pulsar 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.



EMSA #111 B  
(Effective 1/1/2009)

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

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.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

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

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS:</b> <i>Person has pulse and/or is breathing.</i> <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 to hospital if indicated.</b> Includes intensive care. <b>Additional Orders:</b> _____ _____
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<b>C</b> Check One	<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. <b>Additional Orders:</b> _____
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<b>D</b>	<b>SIGNATURES AND SUMMARY OF MEDICAL CONDITION:</b> <b>Discussed with:</b> <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	

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

Patient Name (last, first, middle)		Date of Birth	Gender: <b>M</b> <b>F</b>
Patient Address			
<b>Contact Information</b>			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

**Directions for Health Care Professional****Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

**Using POLST**

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

**Section A:**

- No defibrillator (including automated external defibrillators) 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).
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”

**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 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 void POLST, draw a line through Sections A through D and write “VOID” in large letters. Sign and date this line.
- 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.

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**