



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

**A** **CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse and is not breathing.*  
 Check One  Attempt Resuscitation/CPR  Do Not Attempt Resuscitation/DNR (Allow Natural Death)  
 (Section B: Full Treatment required)  
 When not in cardiopulmonary arrest, follow orders in **B** and **C**.

**B** **MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*  
 Check One  **Comfort Measures Only** 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. **Transfer** if comfort needs cannot be met in current location.  
 **Limited Additional Interventions** 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.  
 **Do Not Transfer to hospital for medical interventions.** **Transfer** if comfort needs cannot be met in current location.  
 **Full Treatment** Includes care described above. 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.*  
 Check One  No artificial nutrition by tube.  Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.  
**Additional Orders:** \_\_\_\_\_

**D** **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**  
 Discussed with:  
 Patient  Health Care Decisionmaker  Parent of Minor  Court Appointed Conservator  Other:  
**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 Phone Number	Date
Physician Signature (required)	Physician License #	

**Signature of Patient, Decisionmaker, Parent of Minor or Conservator**  
 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)
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Summary of Medical Condition	Office Use Only
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**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**