SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Montana Provider Orders for Life-Sustaining Treatment (POLST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- Completing a POLST is **ALWAYS VOLUNTARY**.

Legal Last Name	Legal First Name/Middle Name	Date of Birth

In preparing these orders, inquire if the patient has a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) *****Person has NO pulse and is not breathing.* ****

☐ **YES CPR:** Attempt Resuscitation ☐ **NO CPR:** Do Not Attempt Resuscitation (DNAR)/ Allow Natural Death (AND)

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section When not in cardiopulmonary arrest, follow orders in Section B.*

B — Check one box only

MEDICAL INTERVENTIONS *****Person HAS a pulse and is breathing.*** **

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatments described below in "Selective Treatment" and "Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion, as indicated. Transfer to hospital, if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described below in "Comfort-focused Treatment," use IV antibiotics and IV fluids, as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route, as needed; use oxygen, suctioning, and manual treatment of airway obstruction, if indicated. Do not use treatments listed in "Full Treatment" and "Selective Treatment" above, unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION ** ***If feasible, always offer food & water by mouth.*** **

☐ Artificial nutrition by tube--long term/permanent, if indicated.
☐ Artificial nutrition by tube--short term/temporary only.
☐ No artificial nutrition by tube. ☐ No decision has been made

D

DISCUSSED WITH (check all that apply):

☐ Patient ☐ Legal guardian
☐ Medical Power of Attorney ☐ Other (Name & Relationship):_____

SIGNATURES OF PROVIDER AND PATIENT, Surrogate, Medical Power of Attorney, and Legal GUARDIAN (*MANDATORY*)

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.
Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Power of Attorney, CPR order, Living Will, or other Advance Directive (attach if available).

Patient/Legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	***Relationship/ Decision maker status*** *(Write "self" if patient)*	***Date Signed*** *(Mandatory)*

SIGNATURE OF PROVIDER: **My signature below indicates to the best of my knowledge that these orders are consistent with the patient preferences.**

Name of Person Preparing Form	***Phone number of Preparer***	***Date Performed***

Physician / APRN / PA Signature *(Mandatory)*	***Print Physician / APRN / PA Name***	***Date Signed*** *(Mandatory)*

Directions for Health Care Professionals

Completing POLST

- Completed by a health care professional based on patient preferences and medical indications.
- Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant.
- Patient (or legal decision-maker, if patient unable to make medical decisions), **must sign** to be valid.
- Verbal orders are acceptable with follow-up signature by provider in accordance with organization/ community policy.
- Documentation of conversations regarding POLST completion should be in the medical record.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid. The patient should retain the original on "Terra" Green colored paper.

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 patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi- level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-focused Treatment," should be transferred to a setting able to provide comfort (i.e. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort-focused Treatment."

Section C:

- Certain medical conditions may prevent intake of food and water, as it can worsen symptoms.
- If this applies, further discussion with and documentation by a healthcare provider is required.

Reviewing POLST

- Previously completed advance directives should not conflict with these Montana Provider Orders for Life-Sustaining Treatment (POLST) unless significant discussion and documentation between the patient, legal decision maker and healthcare provider occurs and is documented.
- POLST review is recommended when:
    - The patient is transferred from one care setting or care level to another.
    - There is substantial change in the patient's health care status including previous wishes that conflict with medical recommendations.
    - The patient has a change in treatment preference.

Modifying and Voiding POLST

- At any time a patient or legal decision-maker can void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or completing a new POLST.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date.
- The most recently dated POLST is considered the valid POLST and supersede all prior POLST directives.