HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- Sample -

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

For Patient Education

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:
Patient's Last Name		Patient's First Name	

Preferred Name:	Date of Birth: (mm/dd/yyyy)	Gender:	MRN (optional)
	Date / of / Birth	☐ M ☐ F ☐ X	

Address (street / city / state / zip):

A — CARDIOPULMONARY RESUSCITATION (CPR): *Unresponsive, pulseless & not breathing.*

Check One

■ **Attempt Resuscitation/CPR**
Must check Full Treatment in Section B.

■ **Do Not Attempt Resuscitation/DNR**
If patient not in cardiopulmonary arrest, follow orders in B.

B — MEDICAL INTERVENTIONS: *When patient has a pulse and is breathing.*

Check One

■ **Comfort Measures Only.** Provide treatments to 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.*
Treatment Plan: Provide treatments for comfort through symptom management.

■ **Selective Treatment.** 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.*
Treatment Plan: Provide basic medical treatments.

■ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit, if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C — DISCUSSED WITH: (REQUIRED)

Check All That Apply

☐ Patient ☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.

List all names and relationship: _____

D — PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)

Signature:	Name (print):	Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E — ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)

Must Print Name, Sign & Date

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: ***required***	Signer's Phone Number:	Signer's License Number: *(optional)*

MD / DO / NP / PA / ND Signature: ***required***	Date: ***required***	**"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

*Also known as Physician Orders for Life-Sustaining Treatment

2023

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information Regarding POLST

PATIENT'S NAME: _____

The POLST form is:

- **Always voluntary and cannot be required**
- **A medical order for people with a serious illness or frailty**
- An expression of wishes for emergency treatment in one's current state of health (if something happened today)
- A form that can be changed at any time, with a health care professional, to reflect new treatment wishes
- **NOT an advance directive**, which is ALSO recommended. An advance directive is the appropriate legal document to appoint a health care representative. See ORS 127.527

Contact Information (Optional)

Emergency Contact:	Relationship:	Phone Number:

Health Care Professional's Information

Preparer's Name	Preparer's Title	Phone Number:	Date Prepared:

Primary Care Professional's Name

Directions for Health Care Professionals

Completing Oregon POLST®

- Discussion and attestation should be accompanied by a note in the medical record.
- Any section not completed implies full treatment for that section.
- An order for CPR in Section A requires an order for Full Treatment in Section B, or the form will not be accepted into the Registry.
- Photocopies, faxes and electronically-signed forms are legal and valid.
- Verbal / phone orders from MD/DO/NP/PA/ND in accordance with facility/community policy can be submitted to the Registry.
- For information on determining the legal decision maker(s) for patients who lack capacity and have not appointed a health care representative, **refer to ORS 127.635**
- A person with intellectual or developmental disabilities requires additional considerations before completing the POLST form. Refer to ***Guidelines on POLST Use for Persons with Significant Disabilities who are Now Near the End of Life*** at: osf.io/f852b

Registry Contact Information:

Toll Free: 1-877-367-7657
Fax or eFAX: 503-418-2161
orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: BTE 234
Portland, OR 97239

Patients:

The Registry will mail a confirmation packet to the address listed on the front page in about four weeks.

Updating POLST: POLST forms should be reviewed regularly. A POLST form needs to be revised or voided if patient treatment preferences have changed.

POLST forms should be reviewed routinely, including when:

- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes have not changed, the POLST form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient opted out.

- A person with capacity, or the legal decision maker of a person without capacity, can void the form and request alternate treatment.
- For paper forms, draw a line through sections A through E and write "VOID" and the date. *Note:* Revising a POLST form automatically replaces a previous form in the Registry.
- If included in an electronic medical record, follow your system's ePOLST voiding procedures.
- Regardless of paper or ePOLST form, send a copy of the voided form to the POLST Registry (required unless patient opted out).

For permission to use the copyrighted form, contact OHSU Center for Ethics in Health Care at: polst@ohsu.edu or (503) 494-3965.

Information on the Oregon POLST Program is available online at: **oregonpolst.org** or at **polst@ohsu.edu**

Scan QR Code to access POLST completion and submission information.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

*Also known as Physician Orders for Life-Sustaining Treatment