Wyoming Department of Health

WyoPOLST

Providers Orders for Life Sustaining Treatment

HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

FIRST follow these orders, **THEN** contact the Physician, PA, or APRN. This is a Provider Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Every patient shall be treated with dignity and respect.

Last / First / Middle Name (Place ID Sticker Here if Applicable):

Date of Birth: ____/____/____ Last 4 SSN: ___ ___ ___ ___ Gender: M / F

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **CPR / Attempt Resuscitation** ☐ **DNR / Do Not Attempt Resuscitation (Allow Natural Death)**

When NOT in cardiopulmonary arrest, follow orders in **B and C**

B Check One

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **FULL TREATMENT:** Use intubation, advanced airway interventions, mechanical ventilation and defibrillation/cardioversion as indicated. Includes care described below.
Transfer *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT:** Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BIPAP). Includes treatments listed below. Includes care described below.
Transfer *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED THERAPY:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort.
Patient prefers no transfer*: Transfer if comfort needs cannot be met in current location.*

Additional Orders (e.g. dialysis, etc) _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Oral fluids and nutrition must always be offered if medically feasible.*

☐ Long-term artificial nutrition by tube
☐ Trial period of artificial nutrition by tube
☐ No artificial nutrition by tube

Additional Orders/Patient Goals: _____

D

MEDICAL CONDITION / PATIENT GOALS:

E

___ In initialing this line, I indicate that my instructions on this POLST form may not be changed by my next of kin or medical decision maker if I am incapacitated.

SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences, and best known information.

Discussed with:	Print Primary Health Care Provider Name and Address:	Phone #:
☐ Patient ☐ Parent of a minor ☐ Legal Guardian ☐ Health Care Agent (DPOAHC) ☐ Spouse ☐ Other: _____	Primary Health Care Provider Signature:	Date:
	Patient (or Legal Representative):	Date:

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged, however photocopies and faxes of signed POLST forms are legal and valid.

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Patient Name (Last, First Middle)	Date of Birth:	Gender:
Additional Contact Information (optional)		
Name of Next of Kin, Guardian, Surrogate, or Patient Contact:	Relationship:	Phone Number:

Patient has: ☐ Advanced Directive (or Living Will) ☐ DPOAHC ☐ Organ Donor

Encourage all advance care planning documents to accompany POLST

Directions for Health Care Professional

Completing WyoPOLST

- Completion of WyoPOLST form is VOLUNTARY.
- WyoPOLST is recommended for patients with advanced illness or frailty.
- Must be completed by Wyoming Licensed Health Care Professional based on patient preferences and medical indications.
- WyoPOLST must be signed by a licensed provider and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by licensed provider in accordance with facility/community policy.
- Use of original form is strongly encouraged. Original form should be printed on yellow card-stock, and orignal form should accompany patient. Photocopies and FAXes of signed WyoPOLST forms are legal and valid.
- Additional copies of the WyoPOLST form can be obtained by contacting the Wyoming Department of Health, Aging Division, Community Living Section at 1-800-442-2766.

Using WyoPOLST

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

Section A:

- No defibrillator (including AED) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- Comfort-Focused therapies must always be offered to any patient regardless of level of care selected.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Focused Therapy" 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 Focused Therapy"
- Non-invasive airway techniques 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 "Selective Treatment" or "Full Treatment."

Section C:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing WyoPOLST

It is recommended that WyoPOLST 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 WyoPOLST

- A person with capacity can, at any time, void the WyoPOLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new WyoPOLST form.
- To void WyoPOLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.

Review of WyoPOLST:

Review Date	Reviewer Name/Signature	Reason for Review	Review Outcome
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ No Change ☐ Form Voided ☐ New Form Completed
		☐ Change in Patient Status ☐ Transfer ☐ Annual Review	☐ Change in Patient Status ☐ Transfer ☐ Annual Review