

NOTICE

This is the National POLST Form and can only be *completed* in states that have adopted it (it is valid in most states). Check with your POLST Program (www.polst.org/map) to determine if your state uses this version.

National POLST Form

The National POLST Form is a portable medical order. Health care professionals should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

This form should be obtained from a health care provider.
It should not be provided to patients or individuals to complete.

Printing the National POLST Form

1. **Do not alter this form.**
2. This national form must be adopted by the state before it can be completed in that state as a valid POLST form. Find your POLST Program contact at www.polst.org/map – this is because some states have added information on page 2, have added a border, or have requirements about the color of the form.
3. Print BOTH pages as a double-sided form on a single sheet of paper.

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information.

Having a POLST form is always voluntary.

This is a medical order,
not an advance directive.
For information about
POLST and to understand
this document, visit:
www.polst.org/form

Patient First Name: _____
Middle Name/Initial: _____ Preferred name: _____
Last Name: _____ Suffix (Jr, Sr, etc): _____
DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1	<input type="checkbox"/> YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)	<input type="checkbox"/> NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)
--------	---	---

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1	<input type="checkbox"/> Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
	<input type="checkbox"/> Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
	<input type="checkbox"/> Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).


[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1	<input type="checkbox"/> Provide feeding through new or existing surgically-placed tubes	<input type="checkbox"/> No artificial means of nutrition desired
	<input type="checkbox"/> Trial period for artificial nutrition but no surgically-placed tubes	<input type="checkbox"/> Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)


I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

 (required)			The most recently completed valid POLST form supersedes all previously completed POLST forms.
	If other than patient, print full name:	Authority:	

F. SIGNATURE: Health Care Provider (eSigned documents are valid)

Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

 (required)	Date (mm/dd/yyyy): Required / /	Phone # :
	Printed Full Name:	License/Cert. #:
Supervising physician signature:	<input type="checkbox"/> N/A	License #:

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	<input type="checkbox"/> Legal Representative <input type="checkbox"/> Other emergency contact	Phone #: Day: Night:
------------	---	----------------------------

Primary Care Provider Name:	Phone:
-----------------------------	--------

<input type="checkbox"/> Patient is enrolled in hospice	Name of Agency: Agency Phone:
---	----------------------------------

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	<input type="checkbox"/> Yes; date of the document reviewed (mm/dd/yyyy): ____ / ____ / ____ <input type="checkbox"/> Conflict exists, notified patient (if patient lacks capacity, noted in chart) <input type="checkbox"/> Advance directive not available <input type="checkbox"/> No advance directive exists
---	--

Check everyone who participated in discussion:	<input type="checkbox"/> Patient with decision-making capacity <input type="checkbox"/> Legal Surrogate / Health Care Agent	<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other: _____	<input type="checkbox"/> Parent of Minor
--	--	--	--

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): ____ / ____ / ____	Phone #:
---	---------------------------------------	----------

This individual is the patient's:	<input type="checkbox"/> Social Worker <input type="checkbox"/> Nurse <input type="checkbox"/> Clergy <input type="checkbox"/> Other: _____
-----------------------------------	--

Form Information & Instructions

- **Completing a POLST form:**
 - Provider should document basis for this form in the patient's medical record notes.
 - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
 - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
 - Original (if available) is given to patient; provider keeps a copy in medical record.
 - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
 - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
 - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
 - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
 - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
 - (1) is transferred from one care setting or level to another;
 - (2) has a substantial change in health status;
 - (3) changes primary provider; or
 - (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
 - **If a patient or patient representative (for patients lacking capacity) wants to void the form:** destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
 - **For health care providers:** destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker
---------------------	---------------------------