HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

Massachusetts POLST Form: A Portable Medical Order (adapted from the National POLST form)

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

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

☐ 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

☐ 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.

☐ 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.

☐ 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

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ 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)

I/ (or my patient representative) provide(s) consent to submit this form to the Commonwealth of MA and its POLST Registry. Check here: ☐

If other than patient, print full name:

Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

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

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: ☐ N/A

License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire.

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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:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: Night:
Primary Care Provider Name:		Phone:
☐ 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)	☐ Yes; date of the document reviewed (mm/dd/yyyy):_____/_____/_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

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

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- The Massachusetts POLST Form must be honored by all health care providers.
- Completing a POLST form:
  - Provider should document basis for this form in the patient's medical record notes.
  - A patient's health care proxy may execute or void a POLST form only if the patient lacks decision-making capacity.
  - Only a MD, DO, NP or PA can sign this form.
  - All copies of the POLST are valid. The patient must receive a copy, and a copy must be included in the 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 the conversation, attach a completed 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).
  - 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.mass.gov/POLST
- For additional information, contact the Massachusetts POLST Call Center at 844-771-1629 M-F 9:00AM-5:00PM EST or e-mail POLSTSupport@uhealthsolutions.org Also see the Massachusetts MOLST-to-POLST Transition website www.mass.gov/POLST

State Specific Info	For Barcodes / ID Sticker