MINNESOTA **Provider Orders for Life-Sustaining Treatment (POLST)**

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME

FIRST NAME

DATE OF BIRTH

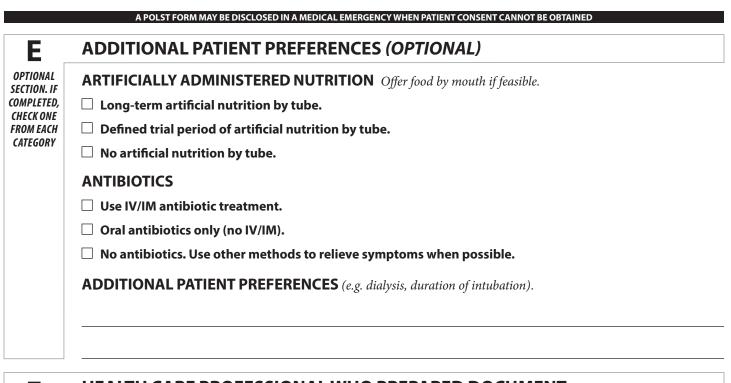
PRIMARY MEDICAL CARE PROVIDER NAME PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

| Λ | CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse and is not breathing. |
|--|--|
| A CHECK ONE | Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B). |
| | □ Do Not Attempt Resuscitation / DNR (Allow Natural Death). |
| | When not in cardiopulmonary arrest, follow orders in B. |
| | |
| B | MEDICAL TREATMENTS <i>Patient has pulse and/or is breathing.</i> |
| CHECK ONE (NOTE REQUIRE- MENTS) | Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. TREATMENT PLAN: Full treatment including life support measures in the intensive care unit. |
| | Selective Treatment. 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. All patients will receive comfort-focused treatments. TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness. |
| | □ Comfort-Focused Treatment (Allow Natural Death). 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: Maximize comfort through symptom management. |
| С | DOCUMENTATION OF DISCUSSION |
| CHECK ALL THAT APPLY | Patient (Patient has capacity) Court-Appointed Guardian Other Surrogate Health Care Agent Health Care Directive |
| | SIGNATURE OF PATIENT OR SURROGATE |
| | SIGNATURE (STRONGLY RECOMMENDED) NAME (<i>PRINT</i>) DATE |
| | RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") PHONE (WITH AREA CODE) |
| | Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above order |
| D | SIGNATURE OF PHYSICIAN / APRN / PA |
| D ALL ITEMS REQUIRED | My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences. |
| | NAME (PRINT)CREDENTIALS (MD, DO, APRN, PA)PHONE (WITH AREA CODE) |
| | SIGNATURE DATE |
| | TFORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VAL |

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INFORMATION FOR

PATIENT NAMED ON THIS FORM



| REQUIRED: |
|------------------|
| CHECK BOX |
| OR COMPLETE |
| ALL ITEMS |

HEALTH CARE PROFESSIONAL WHO PREPARED DOCUMENT

□ Same as signing provider (see Section D)

COMPLETE ILLITEMS NAME (PRINT)

TITLE

PHONE (WITH AREA CODE)

SIGNATURE

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed

DIRECTIONS FOR HEALTH CARE PROVIDERS Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/ APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, health care agent designated in a Health Care Directive, or a person who the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a spouse, domestic partner, adult child, sibling, parent of a minor, other relative or close friend, or closest available relative.

to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a health care agent to speak for you if you are unable to speak for yourself.

Reviewing POLST

This POLST should be reviewed periodically, and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or

DATE

- The patient's treatment preferences change, or
- The patient's primary medical care provider changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through F and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

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