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Physician Orders for Life-Sustaining Treatment (POLST)TM

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

Patient Last Name:	Patient First Name:	Patient Middle Name:	Gender:
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X

Address: (street / city / state / zip):	Date of Birth: (mm/dd/yyyy) ____/____/____
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A	CARDIOPULMONARY RESUSCITATION (CPR): <i>Unresponsive, pulseless, & not breathing.</i>
Check One	<input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR If patient is not in cardiopulmonary arrest, follow orders in B and C .

B	MEDICAL INTERVENTIONS: <i>If patient has pulse and is breathing.</i>
Check One	<input type="checkbox"/> 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.
	<input type="checkbox"/> Limited 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.
	<input type="checkbox"/> Full Treatment. In addition to care described in Comfort Measures Only and Limited 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	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible.</i>
Check One	<input type="checkbox"/> No artificial nutrition by tube. Additional Orders (e.g., defining the length of a trial period): _____ <input type="checkbox"/> Defined trial period of artificial nutrition by tube <input type="checkbox"/> Long-term artificial nutrition by tube.

D	DOCUMENTATION OF DISCUSSION: (REQUIRED) <i>See reverse side for add'l info.</i>
Must Fill Out	<input type="checkbox"/> Patient (If patient lacks capacity, must check a box below) <input type="checkbox"/> Health Care Representative (legally appointed by advance directive or court) <input type="checkbox"/> Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion- see reverse side) Representative/Surrogate Name: _____ Relationship: _____

E	PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT	
	Signature: <u>recommended</u>	This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box: <input type="checkbox"/>

F	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: <u>required</u>	Signer Phone Number:	Signer License Number: (optional)
	MD / DO / NP / PA / ND Signature: <u>required</u>	Date: <u>required</u>	"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 E**

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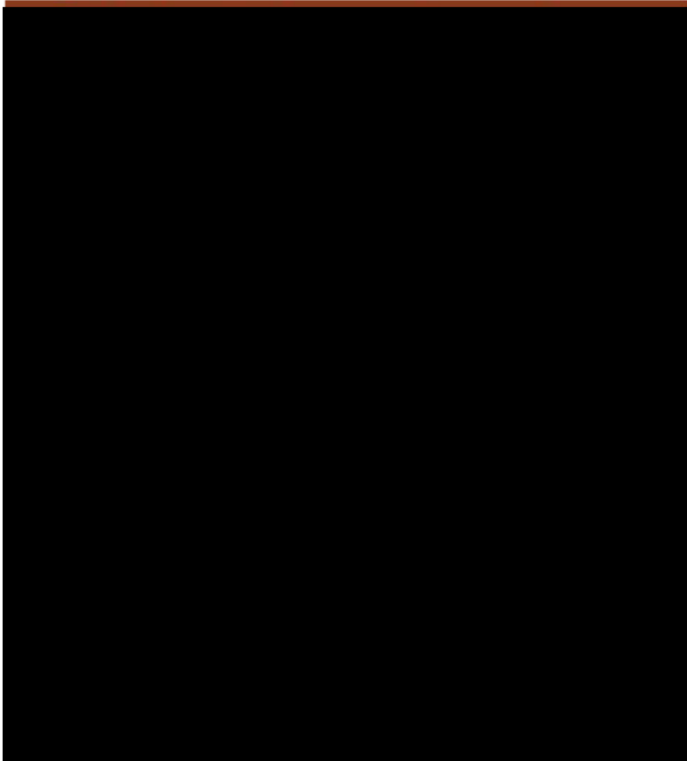
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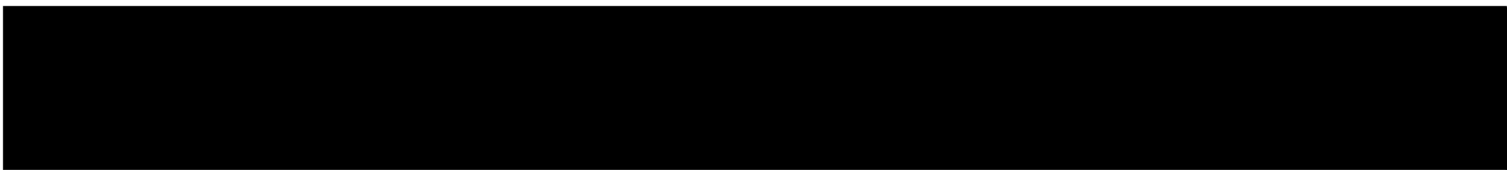
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