provider is not yet aware of, or needs more information about the POLST form, please have them contact the Washington State Medical Association at 1 (800) 552-0612.

Organizations that Endorse the Use of the POLST Form

- Association of Washington Public Hospital Districts
- Washington State Department of Health
- Washington State Hospice & Palliative Care Organization
- Washington State Hospital Association
- Washington State Medical Association
- Regional Ethics Network of Eastern Washington and Northern Idaho

More information about the POLST form can be found at the Washington State Medical Association website at www.wsma.org/polst.

Washington State Medical Association WSMA
Physician Driven Patient Focused

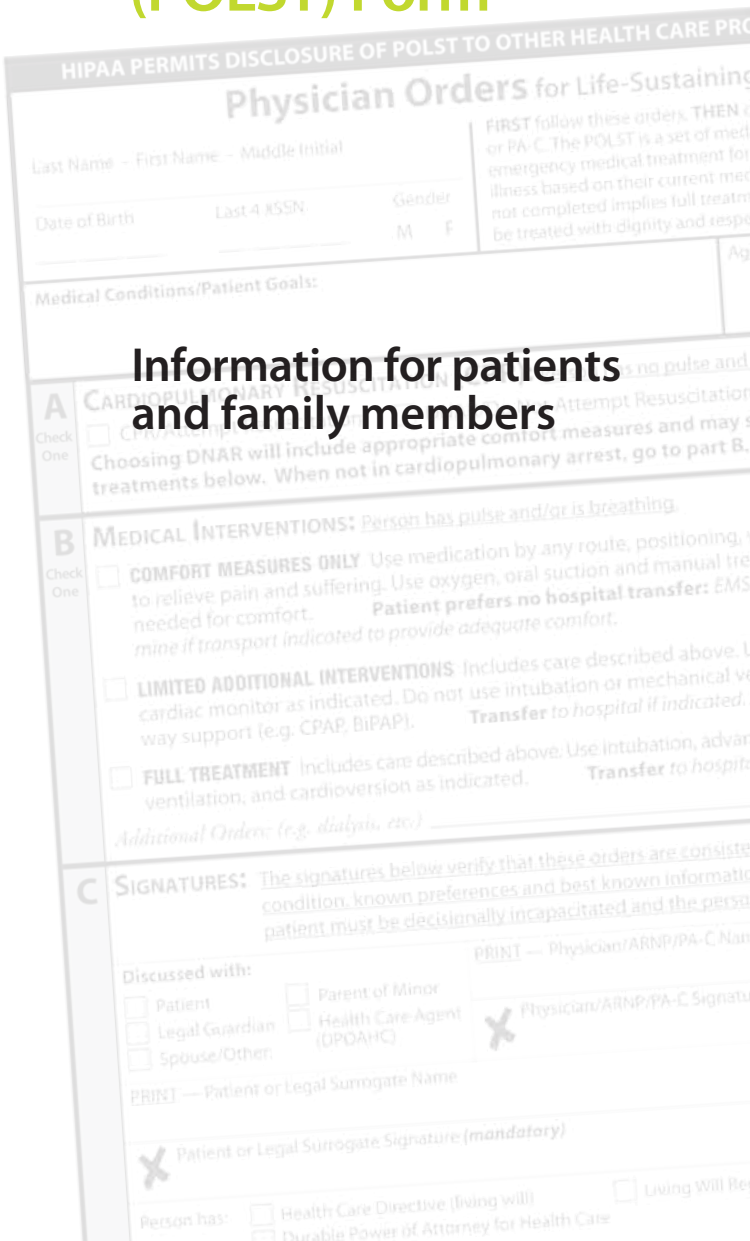
2001 6th Avenue, Suite 2700
Seattle, WA 98121
(206) 441-9762 or 1-800-552-0612

Washington State Department of Health

Department of Health
Office of Community Health Systems
Emergency Medical Services & Trauma Section
P.O. Box 47853
Olympia, WA 98504-7853
(360) 236-2841 or 1 (800) 458-5281

Physician Orders for Life-Sustaining Treatment

(POLST) Form



Information for patients and family members

The POLST form is intended for any individual with serious illness or frailty.

If you have a serious health condition, you need to make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders.

Your physician may use the POLST form to write orders that indicate what types of life-sustaining treatment you want or do not want at the end of life.

The POLST form asks for information about:

- Your preferences for resuscitation
- Medical conditions
- The use of antibiotics
- Artificially administered fluids and nutrition.

The POLST form is voluntary and is intended to:

- Help you and your physician discuss and develop plans to reflect your wishes
- Assist physicians, nurses, health care facilities and emergency personnel in honoring your wishes for life-sustaining treatment
- Direct appropriate treatment by Emergency Medical Services personnel.

Frequently asked questions regarding the POLST form

Does the POLST form need to be signed?

Yes. A physician, nurse practitioner or certified physician assistant (PA-C) must sign the bright green form in order for it to be a physician order that is understood and followed by other health care professionals.

If I have a POLST form do I need an advanced directive too?

If you have a signed POLST form, it is recommended that you also have an advanced directive, though it is not required. You may obtain more information about advanced directives from your physician.

What if my loved one can no longer communicate his/her wishes for care?

If you are the designated health care representative, you can speak on behalf of your loved one. A physician can complete the POLST form based on your understanding of your loved one's wishes.

In what setting is the POLST form used?

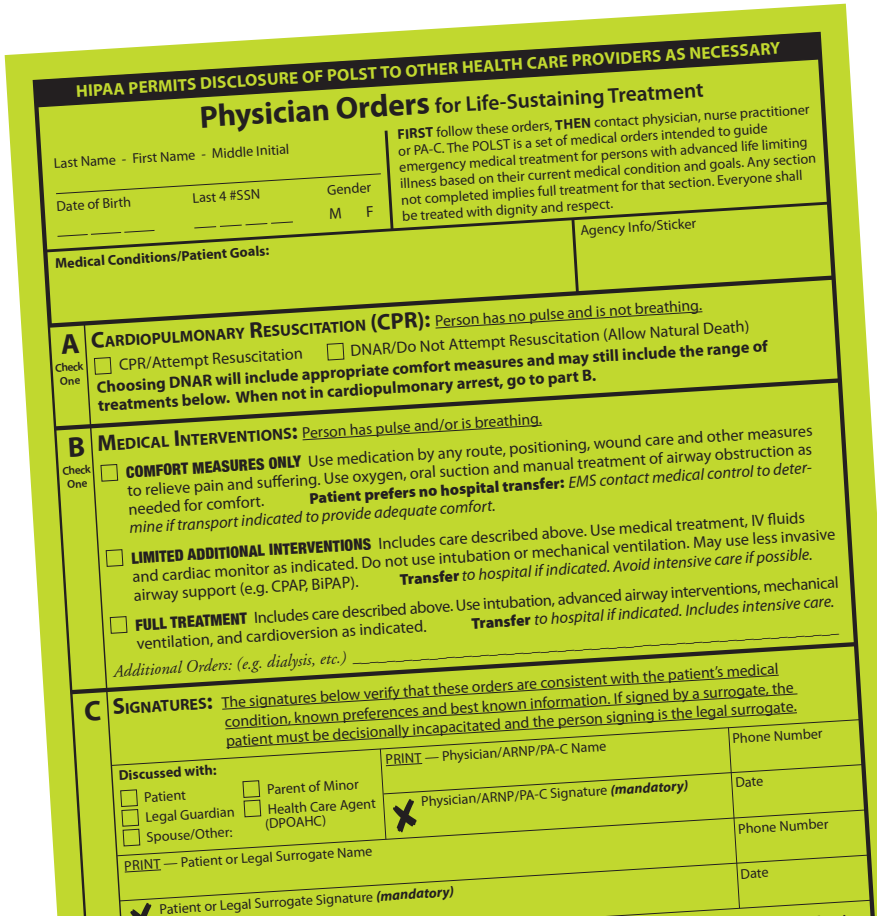
The completed POLST form is a physician order form that will remain with you if you are transported between care settings, regardless of whether you are in the hospital, at home or in a long-term care facility.

Where is the POLST form kept?

If you live at home you should keep the original bright green POLST form in a prominent location (e.g., on the front of the refrigerator, on the back of the bedroom door, on a bedside table or in your medicine cabinet). If you reside in a long-term facility, your POLST form may be kept in your medical chart along with other medical orders.

How do I obtain a copy of the POLST form?

From your physician or other health care provider. If your physician or other health care ▶



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ___ ___ ___ Last 4 #SSN ___ ___ ___ ___ Gender M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Agency Info/Sticker

Medical Conditions/Patient Goals:

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.
☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)
Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Check One — **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.
☐ **COMFORT MEASURES ONLY** 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 hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*
☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. 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). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*
☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*
Additional Orders: (e.g. dialysis, etc.) _____

C **SIGNATURES:** The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Health Care Agent (DPOAHC) ☐ Spouse/Other:

PRINT — Physician/ARNP/PA-C Name — Phone Number

✗ Physician/ARNP/PA-C Signature ***(mandatory)*** — Date

PRINT — Patient or Legal Surrogate Name — Phone Number

✓ Patient or Legal Surrogate Signature ***(mandatory)*** — Date