FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

# GUAM – Physician Orders for Life Sustaining Therapy (POLST)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Date of Birth: | Last 4 SSN: | *(For Patient Identifiers)* |

## A. CHECK ONE

**CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**
**If patient is not in cardiopulmonary arrest, follow orders in B and C.**

☐ **Attempt Resuscitation/CPR**
*(Selecting CPR in Section A requires selecting Full Treatment in Section B)*

☐ **Do Not Attempt Resuscitation**
*(DNAR/no CPR/Allow Natural Death)*

## B. CHECK ONE

**MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**

☐ **Full Treatment.**
In addition to treatment described in **Comfort Measures Only** and **Selected Additional Interventions** *(see below)*, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

**TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.**

☐ **Selected Additional Interventions.**
In addition to treatment described in **Comfort Measures Only** *(see below)*, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

**TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.**

☐ **Comfort Measures Only.**
Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.

**TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.**

**Additional Orders:** _____

## C. CHECK ONE

**MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.**

☐ No medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: _____
☐ Long term medically administered nutrition, including feeding tubes

**Additional Orders:** _____

## D. CHECK ALL THAT APPLY

**INFORMATION AND SIGNATURES**

**Discussed with:**

☐ Patient ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: _____

**Signature of patient or recognized decision maker** *(All fields required)*
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

| Print name: | Signature: | Relationship: |
|---|---|---|
| Address: | | Phone: |

**Signature of authorized healthcare provider** *(All fields required)*
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

| Print name of authorized provider and Physician: | Phone: |
|---|---|
| Signature of authorized provider: | Date: |

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

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## E. ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

Healthcare Directive or other Advance Directive ☐ No ☐ Yes

Durable Power of Attorney for Healthcare Decisions document* ☐ No ☐ Yes

*Name of Agent: _____ Phone: _____

**Health Care Providers Assisting with Form Preparation**

| Name: | Title: | Phone: |
|---|---|---|
| Name: | Title: | Phone: |

**Instructions for Completing POLST**

- Completing a POLST form is always voluntary. POLST is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- POLST is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- POLST must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA; and patient *(or representative)* in compliance with scope of practice, regulation, and state law to be valid.
- Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms are valid. A copy shall be retained in patient's medical record and accompany the patient to all settings.

**Using POLST**

- Any incomplete section of POLST implies full treatment for that section.

**SECTION A:**

– If found pulseless and not breathing, no defibrillator *(including automated external defibrillators)* or chest compressions should be used on a person if "Do Not Attempt Resuscitation" is selected.

**SECTION B:**

– When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort *(e.g., treatment of a hip fracture)*.

– Non-invasive positive airway pressure includes continuous positive airway pressure *(CPAP)*, bi-level positive airway pressure *(BiPAP)*, and bag valve mask *(BVM)* assisted respirations.

**Reviewing POLST**

POLST form should be reviewed when:

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

**Modifying and Voiding POLST**

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decision maker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

**For more information or to obtain more forms: https://polst.org**

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