NEVADA Physician Orders for Life-Sustaining Treatment (POLST)

HIPAA Permits Disclosure to Health Care Professionals & Electronic Registry As Needed For Treatment

SIDE 1: Medical Orders

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. When the need arises, this form should guide treatment decisions. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/First/Middle Initial		
Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
/ /	__ __ __ __	M F

Section A — CPR (Check one only)

Cardiopulmonary Resuscitation (CPR). *Patient/resident has no pulse and is not breathing*

❑ Attempt Resuscitation (CPR) (See Section B: Full Treatment required)

❑ Do Not Attempt Resuscitate (Allow Natural Death) If available, EMS-DNR #_____

❑ Limited Medical Intervention: See Section B

When not in cardiopulmonary arrest follow orders in Section B

Section B — Interventions

MEDICAL INTERVENTIONS. *Patient/resident has pulse and/or is breathing*

1. ❑ Comfort Measures Only. The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. The patient/resident is not to be hospitalized unless comfort measures are not successful.

*Other Instructions:*_____

2. Life-Sustaining Antibiotics

❑ No antibiotics. Use other measures to relieve symptoms

❑ Administer antibiotics by mouth as necessary

❑ Administer antibiotics IV as necessary

*Other instructions*_____

3. Administration of Fluids and Nutrition. Comfort measures always provided.

❑ No feeding tube
❑ Defined trial period of feeding tube
❑ Long term feeding tube
❑ No IV fluids
❑ Defined trial period of IV fluids
❑ Long term IV fluids

*Other Instructions:*_____

4. Other Limitations of Medical Interventions

❑ No intensive care admission
❑ No x-ray
❑ No IV (assure agreement with 2 & 3 above)
❑ No hyperalimentation
❑ No electrolyte or acid/base corrective measures
❑ No lab work
❑ No antiarrhythmic drugs
❑ No dialysis
❑ *Other instructions*:

_____

_____

5. ❑ Full Treatment. Includes care above plus endotracheal intubation and cardioversion.

Section C — Physician Signature

Date	**Physician Signature**	**Physician Name** (print)
Physician Office Address		**Physician Phone**

Send original with patient when discharged or transferred

COPY FOR ARCHIVAL PURPOSES ONLY

EXHIBIT B – HEALTH CARE
Document consists of 2 pages.
Entire exhibit provided.
Meeting Date: 07-10-12

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SIDE 2: Patient Preferences

Section D Organ Donation

ORGAN DONATION

❑ I do not wish to donate my organs

❑ I wish to donate any organs deemed useful

Other Instructions: _____

Section E Advance Directive

The following documents/persons have further information regarding patient's/resident's preferences:

1. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney for Health Care

❑ NO ❑ YES **If no AD skip to 2 below**

AD Registered with Secretary of State: ❑ NO ❑ YES - Registration no.:_____

Other location: _____

Appointed agent #1:_____ Telephone No: _____

Appointed agent #2:_____ Telephone No:_____

2. If no AD contact: _____ Telephone No:_____

3. Court-Appointed Guardian ❑ NO ❑ YES Name: _____

Telephone No: _____

Section F Signatures

Patient / Health Care Agent (Durable Power of Attorney) / Guardian (circle one) **Approval**

I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences.

Signature: _____ Date: _____

The preferences of Sections A and B above were also discussed with and understood by:

❑ Spouse ❑ Adult child ❑ Court-Appointed Guardian

❑ Parent of Minor ❑ Health Care Agent (DPOA) Other: _____

Witnessed by (any checked above):_____ Date: _____

Preparer's Information

Preparer's Name (print) _____ Date: _____

Signature of Person Preparing Form _____

GENERAL INSTRUCTIONS

Record all treatments entered on this POLST as orders in patient's chart.
Copy POLST form for patient record.
If orders change complete a new POLST and write VOID across this POLST.
Transfer or discharge patient with a current POLST form.

WHEN THIS FORM SHOULD BE REVIEWED

This form (POLST) should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

For Internal Use

Send original with patient when transferred or discharged

COPY FOR ARCHIVAL PURPOSES ONLY