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

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth (mm/dd/yyyy)

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION** ☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B Check One

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

Comfort Measures always provided regardless of level of care chosen.

☐ **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 transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

- ☐ Avoid calling 911, call _____ instead (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS -** Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

☐ **FULL TREATMENT -** Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C Check One

Artificially Administered Fluids and Nutrition: Always offer food/fluids by mouth if feasible and desired.

Check One

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Artificial nutrition and hydration unless it provides no benefit.
- ☐ Long-term artificial nutrition by tube.

Additional Orders:

D Must fill out

DOCUMENTATION OF DISCUSSION (Required)

☐ Patient (if patient has capacity)

If patient lacks capacity:

- ☐ A Health Care Directive
- ☐ Health Care Agent
- ☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name Relationship

E

PATIENT or Health Care Agent/Legal Representative (Required)

Signature (Form Does Not Expire) Date of signature

F

ATTESTATION OF MD/DO/APRN/PA (Required)

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 Name of MD/DO/APRN/PA Name Signer Phone Number Signer License Number

MD/DO/PRN/PA Signature: required Date: required Time: required

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Patient's Name			Patient's Date of Birth
Health Care Agent/Legal Representative Name	**Relationship**	**Phone Number**	**Address**
Name of Health Care Professional Preparing Form	**Preparer Title**	**Phone**	**Date Prepared**

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

North Dakota Century Code section 23-12-13 authorizes the following persons to give informed consent for an incapacitated patient in the following order of priority:

a: A health care agent;
b: The appointed guardian or custodian of the patient, if any;
c: The patient's spouse who has maintained significant contacts with the incapacitated person;
d: Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;
e. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person;
f. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person;
g. Grandparents of the patient who have maintained significant contacts with the incapacitated person;
h. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person; or
i. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Completing POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
- POLST must be signed and dated by a physician, advanced practice registered nurse, or physician assistant if delegated, to be valid. Verbal orders are acceptable with follow-up signature by physician, advanced practice registered nurse, or physician assistant if delegated in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- A automatic external defibrillator (AED) should not be used on a patient who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."
- A patient with capacity or the health care representative (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Clarifying POLST

- **Comfort Measures Only:** At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life.
- **Limit Interventions and Treat Reversible Conditions:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective. Comfort Measures will be offered.
- **Full Treatment:** The goal at this level is to preserve life by providing all available medical treatment and advanced life support measures when reasonable and indicated. For patient's designated DNR status in section A above, medical care should be discontinued at the point of cardio and respiratory arrest. Comfort Measures will be offered.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change.
4. The ND POLST form does not expire.

Additional copies of the ND POLST are available here: www.honoringchoicesnd.org/

Faxed copies and photocopies of this form are valid.
To void this form, draw a line across Sections A - D and write "VOID " in large letters.