FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Oklahoma Physician Orders for Life-Sustaining Treatment (POLST)

This Physician Order set is based on the patient's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either, as well as in other cases listed under F. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is legal and valid.

Patient's Last Name/First Name/Middle Initial	
Date of Birth:	
Effective Date of this Form: Form must be reviewed at least annually.	

A. Check One

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

☐ Attempt Resuscitation (CPR) ☐ Do Not Attempt Resuscitation (DNR/ no CPR)

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

B. Check One

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

☐ **Full Treatment** Includes the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardio version as indicated, medical treatment, intravenous fluids, and cardiac monitor as indicated. Transfer to hospital if indicated. Include intensive care. Includes treatment listed under "Limited Interventions" and "Comfort Measures." **Treatment Goal: Attempt to preserve life by all medically effective means.**

☐ **Limited Interventions** Includes the use of medical treatment, oral and intravenous medications, intravenous fluids, cardiac monitoring as indicated, noninvasive bi-level positive airway pressure, a bag valve mask, or other advanced airway interventions. Includes treatment listed under "Comfort Measures." Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. **Treatment Goal: Attempt to preserve life by basic medical treatments.**

☐ **Comfort Measures only** Includes keeping the patient clean, warm, and dry; use of 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 from current location to intermediate facility only if needed and adequate to meet comfort needs and to hospital only if comfort needs cannot otherwise be met in the patient's current location (e.g., hip fracture; if intravenous route of comfort measures is required).

Additional Orders: _____

C. Check One

ANTIBIOTICS

☐ **Use Antibiotics to preserve life.**

☐ **Trial period of antibiotics if and when infection occurs.** **Include goals below in E.*

☐ **Initially, use antibiotics only to relieve pain and discomfort.** *+Contact patient or patient's representative for further direction.*

Additional Orders: _____

D. Check One in Each Column

ASSISTED NUTRITION AND HYDRATION

Administer oral fluids and nutrition, if necessary by spoon feeding, if physically possible.

TPN (Total Parenteral Nutrition- provision of nutrition into blood vessels)	Tube Feeding	Intravenous (IV) Fluids for Hydration
☐ **TPN long-term** if needed	☐ **Long-term feeding tube** if needed	☐ **Long-term IV fluids** if needed
☐ **TPN for a trial period***	☐ **Feeding tube for a trial period***	☐ **IV fluids for a trial period***
☐ **Initially, no TPN+**	☐ **Initially, no tube feeding**	☐ **Initially, no IV fluids+**

Additional Orders: _____

**Include goals below in E. +Contact patient or patient's representative for further direction.*

E. Check all that apply

PATIENT PREFERENCES AS A BASIS FOR THIS POLST FORM

Patient Goals/Medical Condition:

☐ The patient has an advance directive for health care in accordance with Sections 3101.4 or 3101.14 of Title 63 of the Oklahoma Statutes.

☐ The patient has a durable power of attorney for health care decisions in accordance with the Oklahoma Health Care Agent Act.
Date of execution: _____

If POLST not being executed by patient: We certify that this POLST is in accordance with the patient's advance directive.

_____ _____ _____

Name and Position (print) Signature Signature of Physician

Directions given by:

☐ Patient ☐ Minor's custodial parent or guardian ☐ Attorney-in-fact ☐ Health care proxy

☐ Other legally authorized person : _____ Basis of Authority_____

	Printed Name	Signature	Date
Attending Physician			
Patient or other individual checked above (patient's representative)			
Health care professional preparing form (besides doctor)			

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

F.

INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

The POLST form is always voluntary and is usually for persons with advanced illness. Before providing information for or signing it, carefully read "Information for Patients and Their Families – Your Medical Treatment Rights Under Oklahoma Law," which the health care provider must give you. It is especially important to read the sections on CPR and food and fluids, which have summaries of Oklahoma laws that may control the directions you may give. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance health care directive is recommended, regardless of your health status. An advance directive allows you to document in detail your future health care instructions and/or name a health-care agent to speak for you if you are unable to speak for yourself.

The State of Oklahoma affirms that the lives of all are of equal dignity regardless of age or disability and emphasizes that no one should ever feel pressured to agree to forego life-preserving medical treatment because of age, disability or fear of being regarded as a burden.

If this form is for a minor for whom you are authorized to make health care decisions, you may not direct denial of medical treatment in a manner that would violate the child abuse and neglect laws of Oklahoma. In particular, you may not direct the withholding of medically indicated treatment from a disabled infant with life-threatening conditions, as those terms are defined in 42 U.S.C., Section 5106g or regulations implementing it and 42 U.S.C., Section 5106a.

G.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING POLST - **The signature of the patient or the patient's representative is required.**

POLST must be reviewed and prepared in consultation with the patient or the patient's representative after that person has been given a copy of "Information for Patients and Their Families – Your Medical Treatment Rights Under Oklahoma Law ." POLST must be reviewed and signed by a physician to be valid. Be sure to document the basis for concluding the patient had or lacked capacity at the time of execution of the form in the patient's medical record. If the patient lacks capacity, any current advance directive form must be reviewed and the patient's representative and physician must both certify that POLST complies with it. The signature of the patient or the patient's representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature line on this form.

IMPLEMENTING POLST

If a minor protests a directive to deny the minor life-saving treatment, the denial of treatment may not be implemented pending issuance of a judicial order resolving the conflict. A health care provider unwilling to comply with POLST must comply with the transfer and treatment pending transfer requirements of Section 3101.9 of Title 63 of the Oklahoma Statutes as well as those of the Nondiscrimination in Treatment Act, Sections 3090.2 and 3090.3 of Title 63 of the Oklahoma Statutes.

REVIEWING POLST

This POLST must be reviewed at least annually or earlier if:

- The patient is admitted to or discharged from a medical care facility;
- There is a substantial change in the patient's health status; or
- The treatment preferences of the patient or patient's representative change

The same requirements for participation of the patient or patient's representative, and signature by both a physician and the patient or the patient's representative, that are described under "COMPLETING POLST" also apply when POLST is reviewed, and must be documented in Section I.

H.

REVOCATION OF POLST

If POLST is revised or becomes invalid, write in bold the word "**VOID**" in large letters on the front of the form. After voiding the form a new form may be completed. A patient with capacity or the individual or individuals authorized to sign on behalf of the patient in Section E of this form may void this form. If no new form is completed, full treatment and resuscitation is to be provided, except as otherwise provided by Oklahoma law.

I.

REVIEW SECTION: Periodic review confirms current form or may require completion of new form

Date of Review	Location of Review	Patient or Representative Signature	Physician Signature	Outcome of Review
				☐ FORM CONFIRMED – No Change ☐ FORM VOIDED, see updated form ☐ FORM VOIDED, no new form
				☐ FORM CONFIRMED – No Change ☐ FORM VOIDED, see updated form ☐ FORM VOIDED, no new form
				☐ FORM CONFIRMED – No Change ☐ FORM VOIDED, see updated form ☐ FORM VOIDED, no new form

CONTACT INFORMATION:

Patient/Representative	Relationship	Phone number	Email address
Health Care Professional Preparing Form	Relationship	Phone number	Email address