NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

SIDE 1: Medical Orders

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA. Any section not completed implies full treatment for that section.

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

A — Choose 1

CARDIOPULMONARY RESUSCITATION (CPR) – *Patient/resident has no pulse and is not breathing*

❑ Attempt Resuscitation (CPR) ❑ Do Not Resuscitate (Allow Natural Death)_____

When not in cardiopulmonary arrest follow orders in Section B and C

B — Choose 1

MEDICAL INTERVENTIONS – Check only one – *Patient/resident has pulse and/or is breathing.*

❑ **Full Treatment.** ***Goal - prolong life by all medically effective means.***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention in addition to treatment described in Comfort-Focused Treatment and Selective Treatment. Transfer to hospital/admit to ICU as indicated.
*Other Instructions:*_____

❑ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
In addition to Comfort-Focused Treatment use medical treatment, antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally avoid ICU.
*Other Instructions:*_____

❑ **Comfort-Focused Treatment.** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medication by any route as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location.**
*Other Instructions:*_____

C

ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – *offer food & fluids by mouth if feasible or desired*

❑ Long term artificial nutrition, including tube
❑ Artificial nutrition/feeding tube trial no longer than_____
❑ No artificial nutrition or feeding tube
❑ IV fluids trial no longer than _____
❑ No IV fluids
*Other Instructions:*_____

D — Required

CAPACITY DETERMINATION – Completion required by Provider (MD, APRN or PA)

At the time of completing this medical order, the patient:
❑ **Has decisional capacity** ❑ **Lacks decisional capacity**
to understand and communicate their health care preferences for options in this medical order.

E — Bolded Items Required

VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate information on Side 2

Date (Required)	**Physician/APRN/PA Signature (Required)**	**Physician/APRN/PA License # (Required)**
Physician/APRN/PA Name (Printed, Required)	Physician/APRN/PA Phone	

Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian (circle one)
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 wishes / the patient's best known wishes.

Signature_____ Print Name _____Date_____

OR if the patient lacks capacity *and* has no known Agent (DPOA-HC) or guardian, complete the following:
Health Care Surrogate Authorization *Also Requires Completion of Side 2, #1.C.*

Signature_____Date_____

Send original with patient when discharged or transferred

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Patient Name: _____ **DOB:** _____

SIDE 2: Supplementary Information

1. Representative/Surrogate Information – The following may have further information regarding patient's preferences:

A. Advance Directive: AD - Living Will, Declaration, Durable Power of Attorney for Health Care (DPOA-HC) ❑ NO ❑ YES

AD filed with Living Will Lockbox: ❑ NO ❑ YES - Registration #, if known:_____

Other AD location: _____

DPOA-HC – This information must be taken directly from the patient's valid DPOA-HC, not verbally

Appointed agent #1: _____ Telephone No: _____

Appointed agent #2: _____ Telephone No: _____

B. Court-Appointed Guardian ❑ NO ❑ YES Name: _____ Phone: _____

C. Health Care Surrogate: Name (printed): _____

Relationship: _____ Phone: _____

2. PREPARER: Preparer's Name (print):_____ Title/Position (MSW, RN, etc.) _____

3. REGISTRY: Provider initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox (LWL). LWL submission forms at: www.LivingWilllockbox.com

4. ORGAN DONATION

❑ I have documented on my license or state-issued ID that I would like to donate my organs

Terms of Use

- The POLST is ALWAYS VOLUNTARY and may not be mandated for a pa
- The POLST is intended for the seriously ill or frail, and for whom a health ofessiona t be surprised if they died within a year; others should be offered an AD with DPOA-HC de tion.
- This medical order is to be honored in all care settings. In-patient ets should reflect these POLST orders. The POLST is to be followed until replaced by new orders.
- Should a patient have both a DNR Identification and P the most re der should be followed.
- Photocopied, faxed or electronic versions are valid as o quired signa ection E) are included.
- When comfort cannot be achieved in the current setting, t t should be ansferred to a setting that is able to provide comfort.

Completing a POLST

- If a patient lacks decisional capacity ntative (DP HC, guardian or parent of a minor) may complete a POLST. If the patient has no legal representative decisional capacity, then a surrogate may complete a POLST for the patient. Surrogates are, in this order, a spouse, the ority of adult child(ren), parent(s), a majority of adult sibling(s), the nearest other adult relative of the patient by blood or adoption who is reasonably available or "an adult who has exhibited special care or concern fo he patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient".
- A POLST does not replace a Ad e (AD). An AD may designate a decision-maker (DPOA-HC) in the event the patient becomes incapacitate documen tional treatment preferences and should be encouraged to be completed. Always chec inconsistencies between End-of-Life documents and correct as appropriate.
- Compl on of a POLST should f llow a discussion of the patient's goals, values and how their treatment preferences will impac both their le ity and q lity of life.
- Any se reates no presumption about the patient's preferences for treatment for that section.
- Patients discharged home should place the POLST next to their bed or on their refrigerator where EMS is trained to look.

POLST Review - This POLST should be reviewed periodically, and if:

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

Voiding POLST

- If the patient has decisional capacity, only the patient may void a POLST.
- Without decisional capacity, the patient's legal representative may revoke a POLST or, the patient's surrogate may revoke the POLST *only* if the POLST was completed by the patient's surrogate (see Completing a POLST, first bullet, above).

Send original with patient when transferred or discharged