05/2017

NEW HAMPSHIRE

HIPAA PERMITS DISCLOSURE TO HEALTH PROFESSIONALS INVOLVED IN THE PATIENT'S CARE

Provider Orders for Life-Sustaining Treatment (POLST)

This is a Physician/APRN Order Sheet. First follow these orders, then contact physician or APRN. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies **full treatment** for that section.

Patient Last Name

Patient First Name/Middle Initial

Date of Birth (mm/dd/yyyy) _____,_____,_____ | Gender _____

Section A *Check One*

Cardiopulmonary Resuscitation (CPR): Patient has no pulse and/or is not breathing.

☐ **YES, Attempt CPR**

☐ **NO, Do Not Attempt Resuscitation/DNR** Follow orders in B, C and D when not in cardiopulmonary arrest.

This will constitute a DNR order, and no separate DNR Order will be required.

Section B *Check One*

Interventions:

☐ **Full Treatment** – Includes treatment described below, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. **Treatment Plan: Full treatment including life support measures in the intensive care unit.**

☐ **Selective Interventions** – Includes treatments described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital level of treatment to meet need, if indicated. Avoid intensive care. **Treatment Plan: Provide basic medical treatments.**

☐ **Comfort-focused Care** – Use medication by any route, positioning, wo
relieve pain and discomfort. Patient prefers no transfer to hospital for life-su
needs cannot be met in current location. **Treatment Plan: Maximize comfo**

Other Orders (e.g. time limited treatment, hospice evaluation, etc.):

Section C *Check Only One in Each Column*

Medically Administered Fluids and Nutrition. Oral fluids and nutrition must b
with patient's goals of care.

☐ IV fluids long-term for hydration and nutrition
☐ IV fluids for a defined trial period
☐ No IV Fluids for hydration and nutrition

☐ Feeding tube lon
☐ Feeding tube for
☐ No feeding tube

Section D *Check One*

☐ Antibiotics if life prolonging ☐ No antibiotics ☐ Antib

Section E *Check All That Apply*

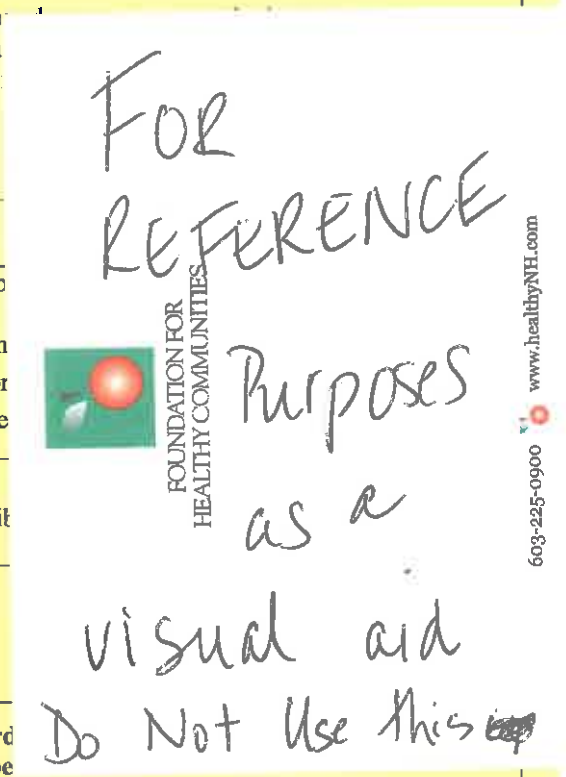
The basis for these orders is:

☐ Patient
☐ DPOAH agent
☐ Court-appointed guardian
☐ Parent(s) of minor
☐ Surrogate
☐ Other (specify):____

**This order has been discussed with the patient named above (or agent, guard
consent as evidenced by signature be**

Documentation of discussion is located in medical chart at:

Date of Discussion:



Mandatory Signature of Patient or Activated DPOAH, Guardian, Surrogate or Parent of Minor, and Physician/ARPN

Name (Print)	**Signature** (Mandatory)	**Date**	**Relationship** (write "self" if patient)

Physician/APRN Name: (Print)	**Physician/APRN Phone Number:**	**Physician/APRN State License Number:**	

Physician/APRN Signature: (Mandatory)	**Date:** (Mandatory)

HIPAA PERMITS DISCLOSURE TO HEALTH PROFESSIONALS INVOLVED IN THE PATIENT'S CARE
Information for Patient Named on this form – Patient's Name (print):

This voluntary form records your preferences for life-sustaining treatment in your current state of health. It can be reviewed and updated by you and your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your DPOAH, Guardian or by your written Advance Care Plan.

(Optional) Contact Information for DPOAH, Guardian or Parent of Minor

Name:	Relationship:	Phone Number:	Address:

(Optional) Health Care Professional Preparing Form

Name:	Preparer Title:	Phone Number:
		Date Prepared:

Directions for Health Care Professionals

Completing POLST

- **Encourage completion of an Advance Directive.**
- **Should reflect current preferences of patient with serious illness or frailty whose death within the next year would not surprise you.**
- **Verbal/phone orders are acceptable with follow-up signature by physician/APRN in accordance with facility policy.**
- **Use original form if patient is transferred/discharged.**

Reviewing POLST

This POLST should be reviewed periodically and if:

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

Voiding POLST

- **A patient with capacity, or the activated DPOAH or Court appointed Guardian of a patient without capacity, can void the form and request alternative treatment.**
- **Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid if in a Health Care facility.**
- **At any time a patient at home or agent or guardian may revoke this POLST by destroying it.**

Review of this POLST Form

Review Date	Reviewer	Location of Review	Signature

Review Outcome: ☐ **No Change** ☐ **Form Voided** ☐ **New form completed**

Review Date	Reviewer	Location of Review	Signature

Review Outcome: ☐ **No Change** ☐ **Form Voided** ☐ **New form completed**

Review Date	Reviewer	Location of Review	Signature

Review Outcome: ☐ **No Change** ☐ **Form Voided** ☐ **New form completed**

ORIGINAL TO ACCOMPANY PATIENT IF TRANSFERRED / DISCHARGED.
FAX OR PHOTOCOPY SHALL BE REGARDED AS VALID IF CONSISTENT WITH FACILITY OR AGENCY POLICY.

Foundation *for*
Healthy Communities