HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT 4/2009

Physician Orders for Life-Sustaining Treatment (POLST)

Maine

First follow these orders, **then** contact physician, NP or PA. 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.	**Last Name / First / Middle Initial**	
	Address:	
	City / State / Zip:	
	Date of Birth:	**Gender: M F**

A *Check One*

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

__Attempt Resuscitation/CPR __ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

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

B *Check One*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing

__**Comfort Measures Only:** Use 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. ***Do Not Transfer to Hospital*** *for life sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current setting.*

__**Limited Additional Interventions:** Includes all care described above. Use medical treatment and monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated.** *Avoid intensive care.*

__**Full Treatment**: Includes all care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer to hospital if indicated***. *Includes intensive care.*

Additional Orders:

C *Check One*

ANTIBIOTICS

__No antibiotics. Use other measures to relieve symptoms.

__Determine use or limitation of antibiotics when infection occurs.

__Use antibiotics if medically indicated.

Additional Orders:

D *Check One for part 1* ***And*** *One for part 2*

ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION: Offer food / liquids by mouth if feasible.

Part 1 – Nutrition:	**Part 2 – Hydration:**
__No artificial nutrition by tube	__No artificially administered fluids
__Trial period of artificial nutrition by tube. Goal:_____	__Trial period of artificial hydration. Goal:_____
__Long-term artificial nutrition by tube.	__Full treatment with artificially administered fluids.

Additional Orders:

E

BASIS FOR ORDERS

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences as indicated by:

Basis for determining patient's preferences (check all that apply)	**Discussion with**: (check all that apply)
__Advance Directive (on file)	__Patient
__Patient's current statement to Physician /NP/ PA	__Parent of a minor
__Patient's statement to authorized representative	__Guardian
__ Best interest determined by authorized representative (no advance directive / preferences unknown)	__ Health Care Agent
	__Other

Print Name of Primary Care Professional	**Phone:**
Print Name of Signing Physician / PA/ NP	**Phone:**
Signature of Physician / PA /NP (required)	**Date:**