F	**Signature of Patient or Authorized Representative**		
	This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences or condition change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by the authorized representative named below.		
	Signature	**Name (print)**	**Relationship (write 'self' if patient)**
	Name of Authorized Representative	**Relationship**	**Address & Phone**

Health Care Professional Preparing Form	**Title**	**Phone**	**Date**

Directions for Health Care Professionals

Completing POLST

- Should reflect patient's preferences based on **current** medical condition. Encourage completion of an advanced directive.
- POLST must be signed by a physician, nurse practitioner or physician assistant to be valid. Verbal orders are acceptable with follow up signature by the physician/NP/PA in accordance with facility /community policy.
- Use of original form is strongly encouraged. Photocopies and faxes are legal and valid.
- Patient should sign this form if (s)he is able to make his/her own health care decisions. If unable to sign, an authorized representative should sign.
- An Authorized Representative includes, in order of priority, a health care agent (same as durable health care power of attorney or agent named in advance directive), court appointed guardian, parent of minor, or surrogate as defined in 18-A MRS § 5-801.

Using POLST

- **Section A**
- No defibrillator (including AED's) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- **Section B**
- 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., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."

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.

Draw a line through sections A through F and write "VOID" in large letters if POLST is replaced or becomes invalid.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED