Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient’s medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

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

- [ ] CPR/ATTEMPT RESUSCITATION
- [ ] DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

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

**MEDICAL INTERVENTIONS:** Patient has pulse and/or is breathing.

*Comfort Measures always provided regardless of level of care chosen.*

- [ ] COMFORT MEASURES ONLY - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
- [ ] Avoid calling 911, call ______________________ instead (e.g. hospice)
- [ ] If possible, do not transport to ER (when patient can be made comfortable at residence)
- [ ] If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

**LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS** - Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatments described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

- [ ] FULL TREATMENT - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

**Artificially Administered Fluids and Nutrition:** Always offer food/fluids by mouth if feasible and desired.

- [ ] No artificial nutrition by tube
- [ ] Defined trial period of artificial nutrition by tube
- [ ] Artificial nutrition and hydration unless it provides no benefit
- [ ] Long-term artificial nutrition by tube

Additional Orders:

**DOCUMENTATION OF DISCUSSION (Required)**

- [ ] Patient (if patient has capacity)
- [ ] If patient lacks capacity:
  - [ ] A Health Care Directive
  - [ ] Health Care Agent
  - [ ] Person legally authorized to provide informed consent (See reverse)

Patient Care Agent/Legal Representative Name
Relationship

**ATTESTATION OF MD/DO/APRN/PA (Required)** By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient’s current medical condition and preferences.

Print Name of MD/DO/APRN/PA Name
Signer Phone Number
Signer License Number

MD/DO/PRN/PA Signature: required
Date: required
Time: required
North Dakota Century Code section 23-12-13 authorizes the following persons to give informed consent for an incapacitated patient in the following order of priority:

a: A health care agent;
b: The appointed guardian or custodian of the patient, if any;
c: The patient's spouse who has maintained significant contacts with the incapacitated person;
d: Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;
e: Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person;
f: Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person;
g: Grandparents of the patient who have maintained significant contacts with the incapacitated person;
h: Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;
i: A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Completing POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
- POLST must be signed and dated by a physician, advanced practice registered nurse, or physician assistant if delegated, to be valid. Verbal orders are acceptable with follow-up signature by physician, advanced practice registered nurse, or physician assistant if delegated in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- A automatic external defibrillator (AED) should not be used on a patient who has chosen “Do Not Attempt Resuscitation.”

Additional copies of the ND POLST are available here: www.honoringchoicesnd.org/

Reviewed POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient’s health status, or
3. The patient’s treatment preferences change.
4. The ND POLST form does not expire.