

How is the POLST form used?

The POLST form is kept near you at all times, usually on your refrigerator or by your bed if you are at home, or in your medical chart if you are in a care facility. It remains with you if you are transported between care settings to assure you receive the treatments you wish.

How do you obtain a POLST?

You can get a copy of the POLST form from your doctor or other healthcare provider, or download it from the Pennsylvania Department of Health's web site, www.health.state.pa.us. The form is located under Quick Links.

POLST

*(Pennsylvania Orders for
Life-Sustaining Treatment)*

**The *Pink Link* to
your wishes for care**
*Information for patients
and family members*



What is POLST?

POLST (Pennsylvania Orders for Life-Sustaining Treatment) is a form printed on bright pink paper that makes a person's wishes for end-of-life care known to doctors, nurses, emergency medical personnel and other healthcare staff.

Who should have a POLST form?

The POLST form is important for people with serious health conditions.

Why should I complete a POLST form?


The POLST form can help you make sure your wishes for care are known and respected. It provides a doctor's order which is required for emergency medical personnel (EMS) and other healthcare workers to follow your plan.

If I have a POLST form, do I need an advance directive too?

Yes, it is recommended that you also have an advance directive. The POLST form reinforces the wishes you express in your advance directive and presents them in an easy to understand way.

What information is on the POLST form?

The form details an individual's treatment preferences when facing a severe illness or injury. It includes information about whether full treatment, cardiopulmonary resuscitation (CPR), tube feedings, antibiotics and comfort measures should be administered.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED To follow these orders, an EMS provider must have an order from his/her medical command physician		
 pennsylvania DEPARTMENT OF HEALTH	Pennsylvania Orders for Life-Sustaining Treatment (POLST)	Last Name First/Middle Initial Date of Birth
FIRST follow these orders. THEN contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.		
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. <input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B, C and D.	
B Check One	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. <input type="checkbox"/> 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. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care if possible. <input type="checkbox"/> FULL TREATMENT Includes 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: <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs, with comfort as goal <input type="checkbox"/> Use antibiotics if life can be prolonged Additional Orders _____	D Check One ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION: Always offer food and liquids by mouth if feasible <input type="checkbox"/> No hydration and artificial nutrition by tube. <input type="checkbox"/> Trial period of artificial hydration and nutrition by tube. <input type="checkbox"/> Long-term artificial hydration and nutrition by tube. Additional Orders _____
E Check One SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES: Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.		
Physician/PA/CRNP/Physio Nurse Name: _____		Physician/PA/CRNP/Physio Nurse Number: _____
Signature (required): _____		Date: _____
Signature of Patient or Surrogate (required): _____		Relationship (write "self" if patient): _____
Name (print): _____		
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Who must sign the POLST form?

A physician, nurse practitioner or certified physician assistant must sign the bright pink form for it to be a physician order that is understood and followed by other healthcare professionals.

What if I want to change something on my POLST form?

The POLST orders can be changed by you and your doctor at any time.

What if I can no longer communicate my wishes for care?

Your designated healthcare representative can speak on your behalf, working with a physician to complete the POLST form.