

Each state that provides for physician orders for life-sustaining treatment (POLST) has its own form and its own name for the form (POLST, MOLST, POST, or MOST). We have provided a sample form based on the POST form from the state of West Virginia as an example. **Because POLST is a medical order, it should be completed only in close collaboration with your treating health care provider, based on a thorough understanding of your current medical circumstances, your priorities and goals of care, and your treatment options in the event of an emergency.** The form provided here is only to familiarize you with the types of treatments the orders will address. POLST is appropriate only for individuals with serious, progressive illnesses or frailty who are at risk of dying within the next year.

You can find links to state-specific POLST forms online in the resource library of the National POLST Paradigm Task Force at [www.polst.org/educational-resources/resource-library](http://www.polst.org/educational-resources/resource-library); select “Forms” under “Resource type.” Nearly half the states have POLST programs in place, and most of the remaining states are in various stages of developing a POLST program. State programs that meet voluntary national standards are referred to as “endorsed” programs and are identified at [www.polst.org](http://www.polst.org).

### **Directions**

When you have downloaded your own state’s form, fill in your name, address, and contact information. After discussing your health care status and goals for intervention with your doctor, fill in the rest of the form together and have your doctor sign it. Then have it filed in your medical record, and keep copies for yourself and others. Like any other medical order, it should be periodically reviewed when your condition changes or goals of care change.

**Physician orders for scope of life-sustaining treatment (POLST)**

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Your first, middle and last names

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Address

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Date of birth

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Last four digits of your Social Security number

Your gender:

- Male     Female

**A. Cardiopulmonary resuscitation (CPR):** Person has no pulse and is not breathing.

Check one box only:

- Resuscitate (CPR)     Do not attempt resuscitation (DNR/no CPR)

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

**B. Medical interventions:** Person has pulse and/or is breathing.

Check one box only:

- Comfort measures.* Treat with dignity and respect. Keep clean, warm, and dry. 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 only if comfort needs cannot be met in current location.

*Treatment plan:* Maximize comfort through symptom management.

- Limited additional interventions.* Includes care described above. Use medical treatment, antibiotics, IV fluids, and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care unit.

*Treatment plan:* Provide basic medical treatments.

- Full interventions.* Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation as indicated. Transfer to hospital if indicated. Include intensive care unit.

*Treatment plan:* Full treatment including life support measures in the intensive care unit.

Additional orders:

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**C. Medically administered fluids and nutrition:** Oral fluids and nutrition must be offered as tolerated.

Check one box only:

- No IV fluids (provide other measures to ensure comfort)
- IV fluids for a trial period of no longer than \_\_\_\_\_
- IV fluids long-term if indicated

Check one box only:

- No feeding tube
- Feeding tube for a trial period of no longer than \_\_\_\_\_
- Feeding tube long-term

Additional orders: \_\_\_\_\_

**D. Discussed with**

- Patient
- Health care surrogate
- Medical power of attorney representative
- Spouse
- Court-appointed guardian
- Parent of minor
- Other (specify) \_\_\_\_\_

**Authorization**

\_\_\_\_\_ Initial if you agree with the following statement: If I lose decision-making capacity and my condition significantly deteriorates, I give permission to my medical power of attorney representative/surrogate to make decisions and to complete a new form with my physician in accordance with my expressed wishes for such a condition, or if these wishes are unknown or not reasonably ascertainable, my best interests.

**Registry opt-in**

\_\_\_\_\_ Initial if you agree to have your POLST form, do-not-resuscitate card, living will, and medical power of attorney form (if completed) submitted to your state registry and related treating health care providers.

\_\_\_\_\_  
Signature of patient/resident, parent of minor, or guardian/medical power of attorney representative/surrogate (mandatory)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician name (print full name)

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date and time

\_\_\_\_\_  
Physician phone number

**E. Patient (parent for minor child) preferences as a guide for this POLST form**

Advance directive (living will or medical power of attorney)

- No    Yes (attach copy)

Organ and tissue document of gift

- No    Yes (attach copy of documentation)

Court-appointed guardian

- No    Yes (attach copy of documentation)

Health care surrogate selection

- No    Yes (attach copy of documentation)

Medical power of attorney/Surrogate/Court-appointed guardian/Parent of minor contact information

Name

Address

Phone

Date

Signature of person preparing form

Preparer name

Date

**Form shall accompany patient when transferred or discharged.**

**F. Review of this POLST form**

This POLST form should be reviewed by the patient or patient’s agent together with the physician if there is substantial change in patient health status or patient treatment preferences. This form *must* be reviewed if the patient is transferred from one health care setting to another. If this form is to be voided, write the word “VOID” in large letters on the front of the form. After voiding the form, a new form may be completed. *If no new form is completed, note that full treatment and resuscitation may be provided.* Keep track of successive reviews by using the chart below.

**POLST review tracking chart**

DATE OF REVIEW	REVIEWER	PHYSICIAN’S SIGNATURE	LOCATION OF REVIEW	OUTCOME OF REVIEW
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, no new form

*Adapted with permission from the West Virginia Physician Orders for Scope of Treatment (POST) 2015.*