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To: Our Oregon Colleagues

The Oregon POLST Task Force is happy to announce the 2014 Oregon POLST Form (Version 9) will be released and authorized for use on October 1, 2014. **Previous versions of the Oregon POLST Form remain valid.**

Like all previous versions, the 2014 POLST Form is a result of changes and updates suggested by POLST stakeholders over the last three years, revisions to other state POLST Forms, and review of POLST Form completion by the Oregon POLST Registry. After review and consideration of over 35 proposed changes, the Oregon POLST Task Force approved Version 9 on June 19th. The 2014 POLST Form is attached for your review along with a summary of the changes.

We want to highlight some major changes:

(1) The previous Section D (which included Documentation of Discussion and Patient/Surrogate Signature and Registry Opt-Out) has been split into two sections. The patient or surrogate signature is still optional (but strongly recommended) in the new Section E, but the Documentation of Discussion (still Section D) is now required. The purpose of this change was to document who the POLST discussion occurred with. Oregon is one of a few states not requiring patient or surrogate signatures on its form and this means patients may find their Oregon POLST Form is not honored in other states that do require a signature. The Task Force believes requiring documentation of discussion will help alleviate that concern.

(2) In Section B, the term “Limited Additional Interventions” was changed to “Limited Treatment”. The Task Force wanted to clarify this *treatment* option and felt this language made the entire Section B more understandable.

(3) We reversed the order of options in Section C (Artificially Administered Nutrition). Sections A and C now have the most aggressive treatments listed first; Section B has the most aggressive treatment option listed last. In making this change, the Task Force was trying to emphasize the neutrality of the Oregon POLST Form with respect to treatment options.

(4) The physician statement and signature section (now Section F) is now an attestation that the health care professional (MD, DO, NP, PA) that the medical

orders in the form are consistent with the patient's current medical condition and preferences.

(5) Other edits- We've:

a. Added reminders to send *both* sides of the form to the Registry.
b. Added a statement on page 2 that patients should consider reviewing their advance directive and giving a copy of it to their health care professional.
c. Added additional information under directions to health care professionals for completion of the form.
d. Removed the requirement that Section A (CPR/DNR) be completed for a form to be accepted by the Registry. If this section is left place, like all other sections on this form, the default is the most aggressive treatment.
e. Emphasized that a POLST Form only needs to be revised if the patient treatment preferences have changed. If there is no change, no new POLST Form is needed.
f. A reminder to send copies of voided POLST Forms to the Registry.

We will be distributing copies of the new form in October. Entities interested in printing their own forms should contact the Oregon POLST Program at polst@ohsu.edu or call (503) 494-3965.

Currently valid Oregon POLST Forms do not need to be filled out again but the 2014 POLST Form should be used in for any future revisions or new POLST Forms.

If you are interested in scheduling education about the Oregon POLST Program or the new POLST Form, please contact Faith at polst@ohsu.edu. We are currently revising our educational materials to reflect the changes in the form and will make those available on the new Oregon POLST website (www.or.polst.org).

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name:	Patient First Name:	Patient Middle Name:	Last 4 SSN: ☐☐☐☐
Address: (street / city / state / zip):		Date of Birth: (mm/dd/yyyy) ______ /______ /_______	Gender: ☐ M ☐ F

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***Unresponsive, pulseless, & not breathing.***

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

If patient is not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — Check One

MEDICAL INTERVENTIONS: ***If patient has pulse and is breathing.***

☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, 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.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital*** *if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: ____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible.***

☐ Long-term artifical nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ No artifical nutrition by tube.

Additional Orders (e.g., defining the length of a trial period): ________________________
____

D — Must Fill Out

DOCUMENTATION OF DISCUSSION: (REQUIRED) ***See reverse side for add'l info.***

☐ Patient (If patient lacks capacity, must check a box below)

☐ Health Care Representative (legally appointed by advance directive or court)
☐ Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion- see reverse side)

Representative/Surrogate Name: ______________________ Relationship: __________________

E

PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT

Signature: ***recommended***	This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box: ☐

F — Must Print Name, Sign & Date

ATTESTATION OF MD / DO / NP / 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 Signing MD / DO / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*
MD / DO / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

DO NOT COPY

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Information for patient named on this form PATIENT'S NAME: ____________________

The POLST form is **always voluntary** and is usually for persons with serious illness or frailty. POLST records your wishes for medical treatment in your current state of health (states your treatment wishes if something happened tonight). Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. No form, however, can address all the medical treatment decisions that may need to be made. An Advance Directive is recommended for all capable adults and allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself. Consider reviewing your Advance Directive and giving a copy of it to your health care professional.

Contact Information (Optional)

Health Care Representative or Surrogate:	Relationship:	Phone Number:	Address:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			

DO NOT COPY

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- An order of CPR in Section A is incompatible with an order for Comfort Treatment Only in Section B (will not be accepted in Registry).
- For information on legally appointed health care representatives and their authority, refer to ORS 127.505 - 127.660.
- Should reflect current preferences of persons with serious illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by MD/DO/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at www.or.polst.org.

Oregon POLST Registry Information

Health Care Professionals:

(1) You are ***required*** to send a copy of both sides of this POLST form to the Oregon POLST Registry unless the patient opts out.

(2) The following sections must be completed:
- Patient's full name
- Date of birth
- MD / DO / NP / PA signature
- Date signed

Registry Contact Information:

Phone: 503-418-4083
Fax or eFAX: 503-418-2161
www.orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: CDW-EM
Portland, Or 97239

Patients:

Mailed confirmation packets from Registry may take four weeks for delivery.

MAY PUT REGISTRY ID STICKER HERE:

Updating POLST: A POLST Form only needs to be revised if patient treatment preferences have changed.

This POLST should be reviewed periodically, including when:

- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes haven't changed, the POLST Form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient has opted-out.

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry (**required** unless patient has opted out).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care at polst@ohsu.edu or (503) 494-3965.
Information on the Oregon POLST Program is available online at **www.or.polst.org** or at **polst@ohsu.edu**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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