HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial: Thankamma, Omana

Date of Birth: 02/23/42 | Last 4 #SSN: ____ | Gender: M (F)

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

EX_POLST

Agency Info/Sticker

A Check One

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

☐ CPR/Attempt Resuscitation ☒ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Check One

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **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 hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☒ **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: (e.g. dialysis, etc.) no intubation

C

SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with:
☐ Patient ☐ Parent of Minor
☒ Legal Guardian ☐ Health Care Agent (DPOAHC)
☐ Spouse/Other:

PRINT — Physician/ARNP/PA-C Name: Elizabeth Schink, MD — Phone Number:

✗ Physician/ARNP/PA-C Signature ***(mandatory)***: Elizabeth Schink, MD — Date: 12/27/18

PRINT — Patient or Legal Surrogate Name: Channa Copeland — Phone Number:

✗ Patient or Legal Surrogate Signature ***(mandatory)***: consent obtained over phone from Channa Copeland, witness: (Evan Luxenberg) — Date: 12/27/18

Person has: ☐ Health Care Directive (living will) ☐ Living Will Registry ☒ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 2/2011 Photocopies and FAXes of signed POLST forms are legal and valid. May make copies for records

Washington State Medical Association WSMA Physician Driven Patient Focused

Washington State Department of Health

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