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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name	
First/Middle Name	
Date of Birth	Date Form Prepared

A — CARDIOPULMONARY RESUSCITATION (CPR): *** Person has no pulse and is not breathing ****

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNAR** (**A**llow **N**atural **D**eath)

(Section B: Full Treatment required)

If the patient has a pulse, then follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *** Person has pulse and/or is breathing ****

Check One

☐ **Comfort Measures Only** 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. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Always offer food and liquid by mouth if feasible and desired.*

Check One

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

Check One

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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Patient Name (last, first, middle)	Date of Birth	Gender M F

Patient's Preferred Emergency Contact or Legally Authorized Representative

Name	Address	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

E SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS
(Legally Authorized Representative as outlined in section D)

I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.

Signature (required)	Name	Relationship

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Completing POLST
- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician or Advanced Practice Registered Nurse (APRN) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST
- Any incomplete section of POLST implies full treatment for that section.

Section A:
- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:
- A patient or a legally authorized representative may make decisions regarding artficial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST
- A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kōkua Mau – Hawai'i Hospice and Palliative Care Organization

Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokuamau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014

Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED