This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.

**IMPORTANT:** See page 2 for complete instructions.

### MEDICAL CONDITIONS / INDIVIDUAL GOALS:

**A**

**Use of Cardiopulmonary Resuscitation (CPR):** When the individual has NO pulse and is not breathing.

- [ ] YES – Attempt Resuscitation / CPR (choose FULL TREATMENT in Section B)
- [ ] NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death

**B**

**Level of Medical Interventions:** When the individual has a pulse and/or is breathing.

- [ ] FULL TREATMENT – Primary goal is prolonging life by all medically effective means. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
- [ ] SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
- [ ] COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis):

**C**

**Signatures:** A legal medical decision maker (see page 2) may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- [ ] Individual
- [ ] Parent(s) of minor
- [ ] Guardian with health care authority
- [ ] Legal health care agent(s) by DPOA-HC
- [ ] Other medical decision maker by 7.70.065 RCW

**SIGNATURE – MD/DO/ARNP/PA-C (mandatory)**

**DATE (mandatory)**

**PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory)**

**PHONE**

**SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)**

**RELATIONSHIP**

**DATE (mandatory)**

**PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)**

**PHONE**

Individual has:
- [ ] Durable Power of Attorney for Health Care
- [ ] Health Care Directive (Living Will)

Encourage all advance care planning documents to accompany POLST.

**SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED**

All copies, digital images, faxes of signed POLST forms are valid. See page 2 for preferences regarding medically assisted nutrition. For more information on POLST, visit [www.wsma.org/POLST](http://www.wsma.org/POLST).
This page contains instructions for Health Care Professionals on how to use the POLST form, which stands for Prescribed Outline of Primary Care. The POLST is a medical order sheet that helps in making decisions about medical care when an individual is no longer able to make decisions. It is primarily intended for out-of-hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders that replaces previous orders and should be reviewed whenever there is a substantial change in the individual's health status, the individual is transferred from one care setting or care level to another, or the individual's treatment preferences change.

### Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

- **Preference is to avoid medically assisted nutrition.**
- **Preference is to discuss medically assisted nutrition options, as indicated.**
  
  *Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).*

*Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have known wishes not to have oral feeding continued; the directions for oral feeding may be subject to these known wishes.*

**Discuss with:** 

- Individual
- Health Care Professional
- Legal Medical Decision Maker

### Directions for Health Care Professionals

- **Any incomplete section of POLST implies full treatment for that section.**
- **This POLST is valid in all care settings.** It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders that the most recent POLST replaces all previous orders.

#### Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual’s preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid.
- Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.

#### Honoring POLST

- Everyone shall be treated with dignity and respect.
- **SECTIONS A AND B:**
  - No defibrillator should be used on an individual who has chosen “Do Not Attempt Resuscitation.”
  - When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
  - Treatment of dehydration is a measure which may prolong life.
- An individual who desires IV fluids should indicate “Selective” or “Full Treatment.”

#### Reviewing POLST

- This POLST should be reviewed whenever:
  - The individual is transferred from one care setting or care level to another.
  - There is a substantial change in the individual’s health status.
  - The individual’s treatment preferences change.

- **To void this form, draw a line across the page and write “VOID” in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.**

### Review of this POLST Form

- Use this section to update and confirm order and preferences.
- This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

<table>
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<th>REVIEW DATE</th>
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<td>New Form Completed</td>
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</tbody>
</table>

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Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records. For more information on POLST, visit www.wsma.org/POLST.