~Exploring the Oregon Advance Directive, the Oregon POLST, and More~

Why am I Here Today?

A daughter of the Patient:

"I don't know what my dad wants … he would not want to be kept alive just hooked up to machines and tubes, not even knowing that I am here..... But he is a fighter."

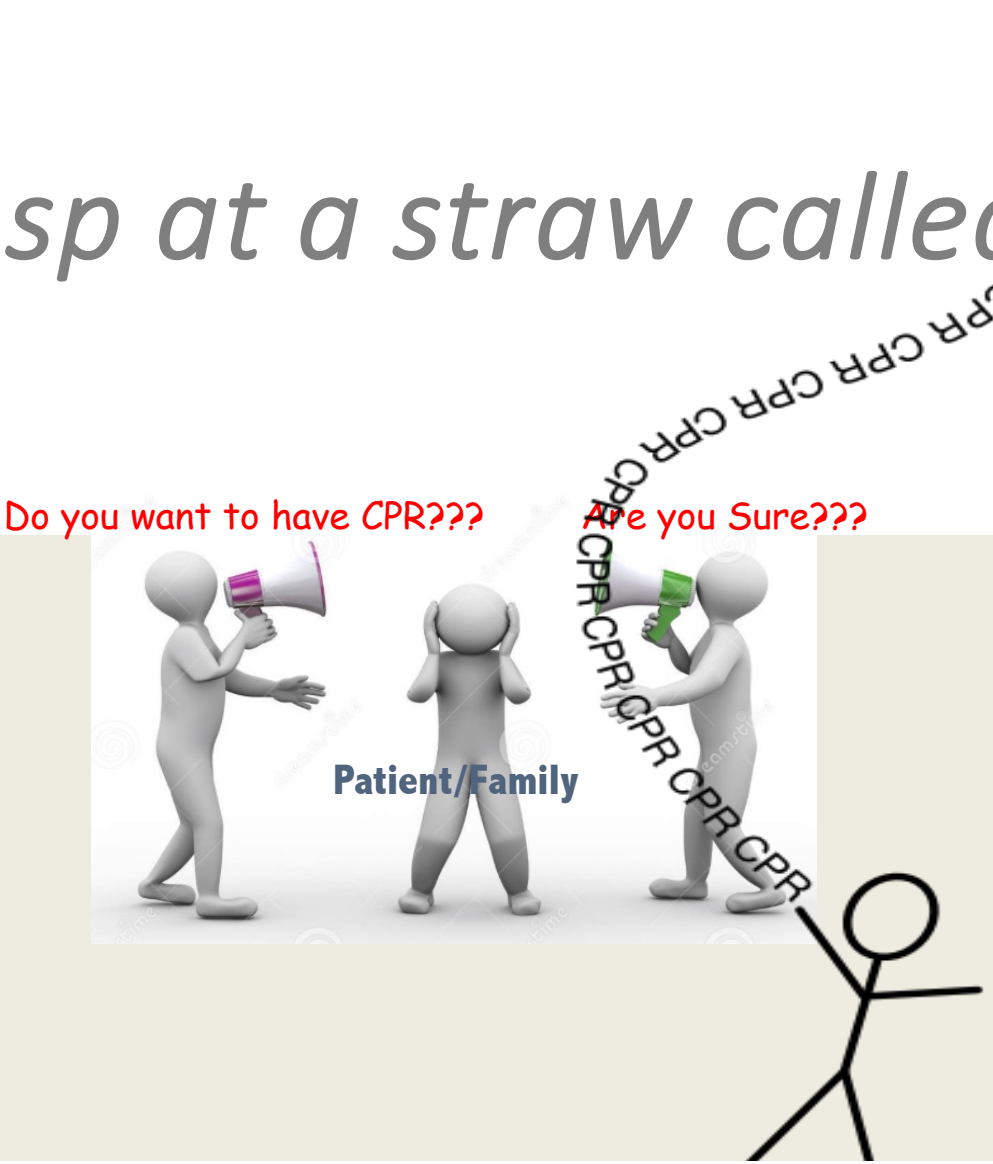
"I don't want him to suffer any more …

But I feel like I am ***KILLING HIM if I ask to 'stop' the machine … This is too hard…***

"I wish I knew what he would have wanted."


In a DIRE
Situation ...

…we grasp at a straw called "CPR".



CPR: Cardiopulmonary Resuscitation

Emergency procedure performed when the heart stops beating and no breathing

= DEATH

Unfortunately..
CPR Success Rate is Low

If patients are in the hospital, they have an <u>average</u> **15-22%** chance of discharged from the hospital alive.

If patients are <u>older, frail, or have uncurable disease</u>, they have a **less than 5%** chance of live discharge and will **typically pass away within several months.**

1. Discuss Advance Care Planning → **<u>What are your priorities?</u>**
2. Describe how to choose your Health Care Representative(s).
3. Describe the functions of the Oregon Advance Directive.
4. Describe when it is appropriate to complete the Oregon POLST.
5. Discuss how the Advance Directive and POLST work together to support your Advance Care Planning.
6. **<u>Always be kind to and love your family and friends!</u>**

Why talking matters

82% of people say it's important to put their wishes in writing.

23% did it

60% of people say that making sure their family is not burdened by tough decisions is extremely important.

56% did NOT do it

90% of people say that talking with their loved ones about end-of-life care is important.

27% did it

[The Conversation Project - Have You Had The Conversation?]

80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

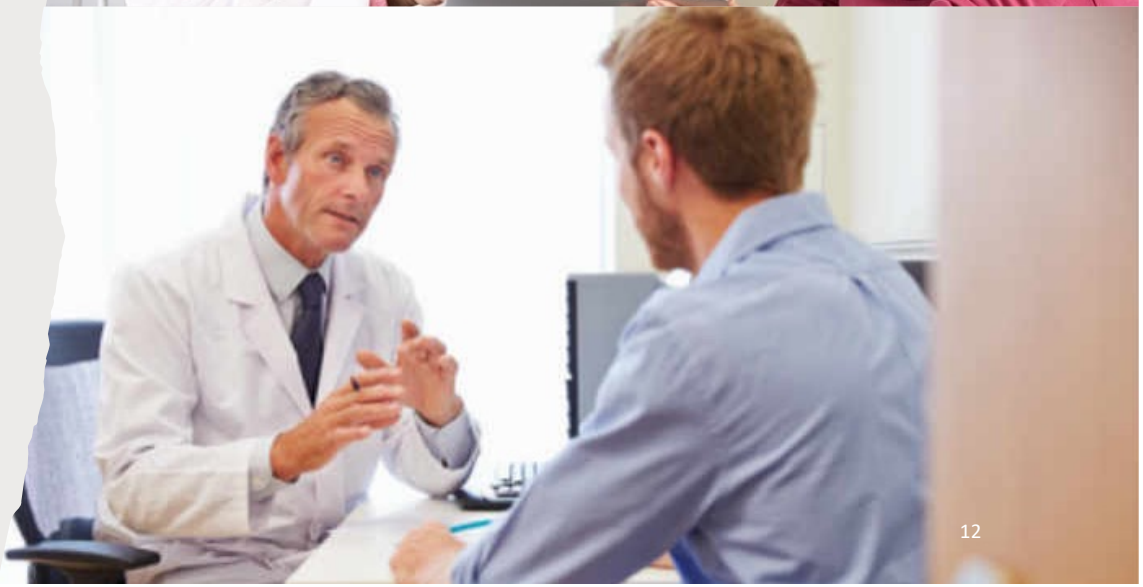
7% did it

Advance Care Planning

- Involves discussing and preparing for future decisions about your medical care, should you become very sick and unable to communicate your wishes.
- The most important step is having meaningful conversations with your loved ones.

Advance Care Planning

- You have a say in your care. Treatments only work if they work for you.
- Tell your doctors what matters most to you, so that you will get the care that's right for you.
- **Available as a Medicare-covered service.**
- Medicaid and most insurances also cover this type of "visit".

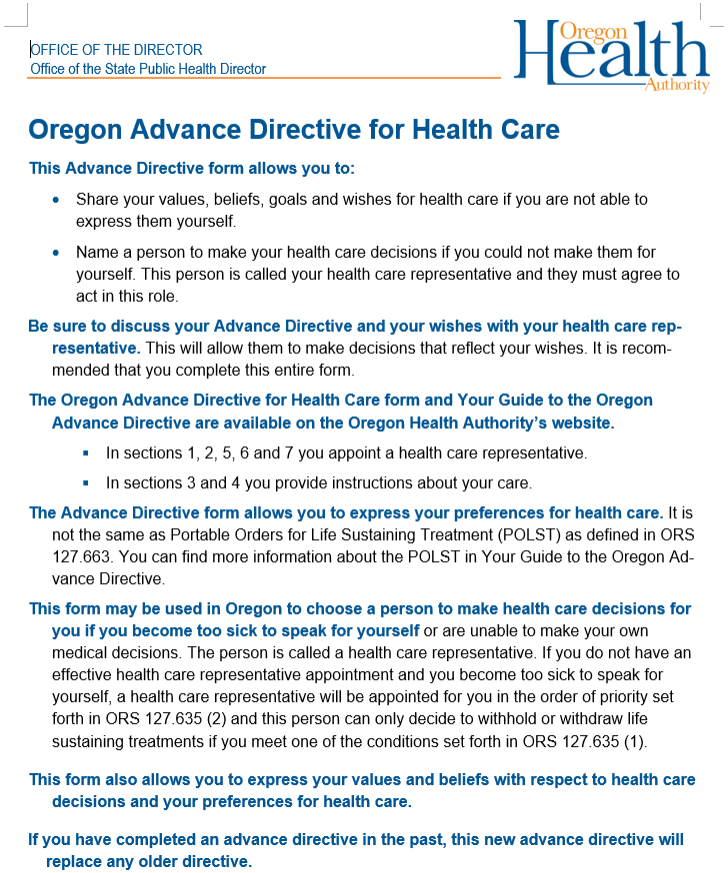


Advance Directives

- Legal documents with medical care instructions that **only go into effect** if you can't communicate your own wishes.
- Help to create your medical care plan by:
  1. having someone who knows your wishes (a **Health Care Representative**) participate in shared decision making on your behalf

     AND/OR

  2. providing your written preferences or instructions.



OFFICE OF THE DIRECTOR
Office of the State Public Health Director

Oregon Health Authority

Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive will replace any older directive.

Choosing a Health Care Representative (HCR)

1. Someone you are comfortable talking with
2. Someone who will honor your wishes and do as you ask
3. Someone who is trustworthy
4. Someone who can handle others' conflicting opinions
5. Someone who is willing and available to serve
6. Need not be a family member
7. You can have more than one

Who makes these decisions if you don't have a Health Care Representative?

Oregon: ORS 127.635
Withdrawal of life-sustaining procedures

… if the principal **does not have an appointed health care representative or applicable valid advance directive,** the principal's health care representative shall be the first of the following, in the following order, who can be located with reasonable effort by the health care facility and who is willing to serve as the health care representative:

(a) A **guardian** of the principal who is authorized to make health care decisions, if any;
(b) The principal's **spouse**;
(c) An adult designated by the others listed in this subsection who can be so located, if no person listed in this subsection objects to the designation;
(d) A majority of the **adult children** of the principal who can be so located;
(e) Either **parent** of the principal;
(f) A majority of the **adult siblings** of the principal who can be located with reasonable effort; or
(g) Any adult relative or adult friend.

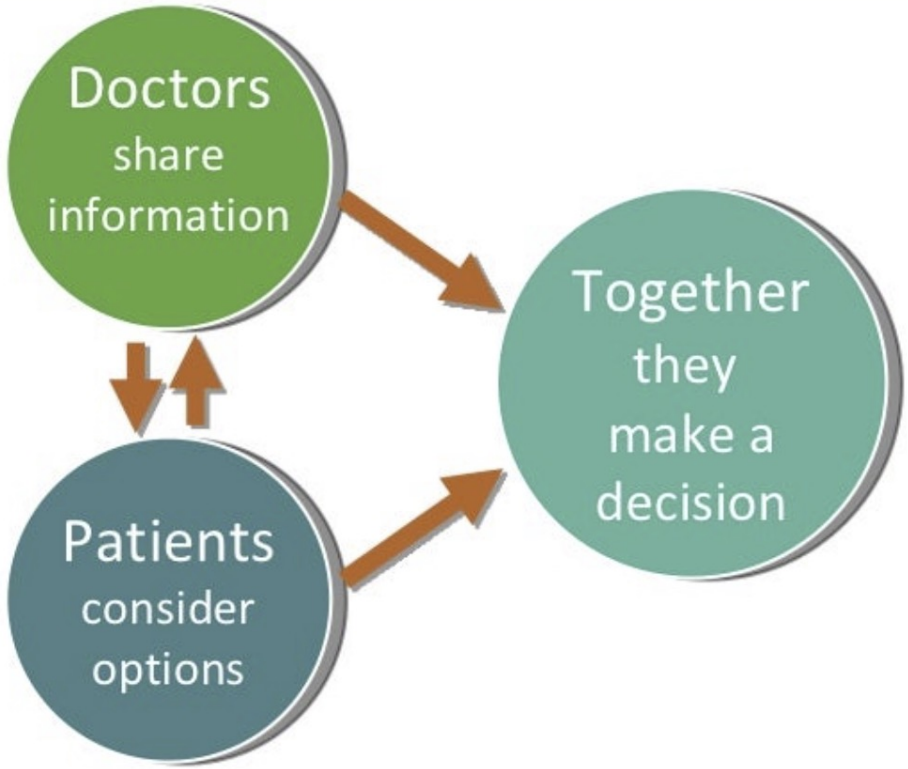
If none of these are available, *life-sustaining procedures may be withheld or withdrawn on the direction and* ***under the supervision of the attending physician or attending health care provider.***

Shared-Decision-Making

A process in which clinicians and patients work together to make decisions regarding **"Whole Person Care"** plans, based on clinical evidence that balances risks and expected outcomes with patient goals, values and preferences.

- **Patient is the *personal* expert**
- **Medical Providers and/or team are the *clinical* experts**

Partnership



What does the Oregon Advance Directive Do?

1. **Appoints a Health Care Representative**

- Oregon allows you to appoint up to **3** representatives,
- One **primary** and **two alternates (optional)**,
- Only one can serve at a time,
- Each HCR must accept the appointment,
- Your HCR's will stand in for you during any shared decision-making conversations.

What does the Oregon Advance Directive Do?

2. Provides written medical instructions, based on your personal preferences

- You can choose the options presented in the multiple-choice form,
- You can write your own narrative,
- You can attach a supplementary document as an official part of your Advance Directive instructions.

Let's Examine Oregon's Advance Directive

OFFICE OF THE DIRECTOR
Office of the State Public Health Director

Oregon Health Authority

Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make **ealth care decisions for** you if you become too sick to speak for yourself or are unable to make your own ve. If you do not have an too sick to speak for the order of priority set old or withdraw life ORS 127.635 (1).

beliefs with respect to health care

If you have completed an advance directive in the past, this new advance directive will replace any older directive.

Oregon's Advance Directive Sections

Preamble

Directions

1. About Me
2. *Names of Health Care Representatives*
3. *Medical Care Preferences*
4. **Additional Information**
5. Signature of Principal
6. Witness **or** Notarization
7. *Signatures of Health Care Representative(s) to accept appointment*

** 1, 5, 6, **and either** 2 or 3, ideally both, should be completed. Once section 2 is completed, section 7 must be completed, too.*

Section 1. About Me

- Name
- Date of Birth
- Contact Information

Section 2. My Health Care Representative

Choose Up to 3 : Primary and 1st, 2nd alternate HCRs are optional

- Name
- Relationship
- Contact information for each HCR

Page 2-3 of AD form

Advance Directive Form

1. About me		
Name (first, middle, last):		Date of birth:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

2. My health care representative		
I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.		
Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

Section 3: My Health Care Instructions

Page 3 of AD form

You can express your wishes, values, and goals for your care.

Your answers can help your health care providers:

they can suggest <u>care right for you.</u>

This is VERY important especially **<u>IF</u>** <u>you have not chosen a HCR.</u>

Section 3-A. My Health Care Decisions

Page 3-6 of AD form

Medical Care Preferences

✓ **Three Scenarios:**

✓ **Four possible medical care choices for each scenario**: **<u>Chose only one</u>**

- ❑ Try **all available** treatments to sustain my life
- ❑ Try **artificial feeding and fluids** only to sustain my life
- ❑ **No** Life-Sustaining Treatments
- ❑ **Health Care Representative** to decide after talking with my providers

✓ **A space is also provided where you can write more about what kind of care you <u>do</u> or do not want.**

All Available Treatments

GOAL: Achieve QUANTITY

CPR:

Cardiopulmonary Resuscitation

ECMO:

Extracorporeal Membrane Oxygenation

Intubation:

A “breathing machine”

Dialysis

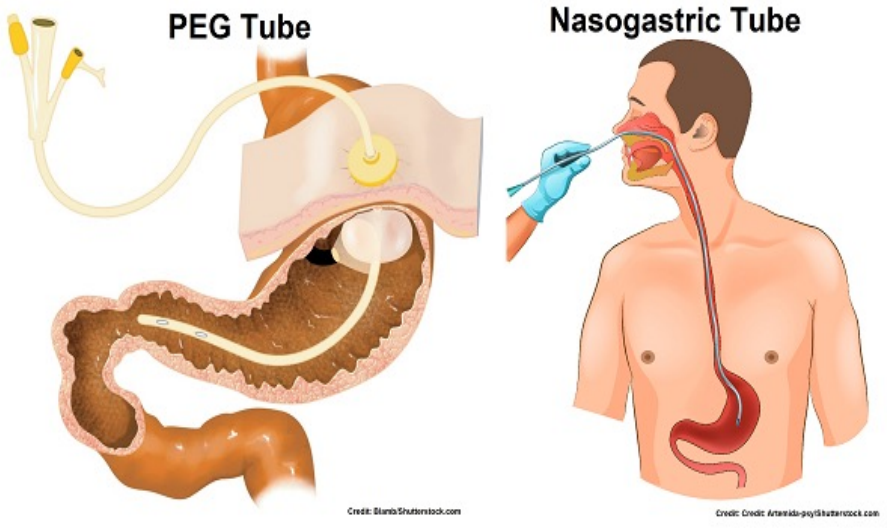
Surgery/Procedures

Medications

Artificial Feeding and Fluids Only

GOAL: Achieve Quality & QUANTITY

- A feeding tube is a treatment that provides life-sustaining **food** and via tubes, when you can no longer eat or drink.
- Artificial hydration provides **water and fluids** through a tube or IV.
- Tube feeding can be given either by a tube through the nose down to the stomach or through the abdomen directly into the stomach (Percutaneous Endoscopic Gastrostomy: PEG→ which involves a procedure).
- Tube feeding can be given for either **short term** or for **a long time** (indefinitely).
- Without fluids, death occurs in 1-4 weeks.



No Life-Sustaining Treatments

GOAL: Achieve QUALITY & Quantity

- Focus can be "**Comfort Measures Only (CMO)** ": treat pain and other symptoms
- No CPR/Intubation
- Usually, not starting new artificial hydration or feeding tubes
- Usually, not starting new dialysis
- What about antibiotics and other medications for blood pressure, cholesterol, diabetes, etc.?
- Can have hospital care with selected treatment options.

Can be Negotiable!

Section 3-A. Medical Care Preferences

Page 4 of AD form

Terminal Condition

I have an illness that cannot be cured or reversed

AND

My health care providers believe it will result in my death within six months, regardless of any treatments.

Jose, Age 68

Jose was diagnosed with very **advanced cancer** and does not expect to live more than 6 months. There is no further treatment available for his cancer.

Other common conditions in this category:

- **Advanced Heart disease**
- **Advanced lung disease**
- **Advanced Kidney disease**

Section 3-A: Medical Care Preferences

Page 4-5 of AD form

Advanced Progressive Illness

I have an illness in an advanced stage.

AND

My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

My health care providers believe I will never:

* Communicate with or recognize family and others
* Swallow food and water safely
* Care for myself

George, Age 78

George has been diagnosed with Alzheimer's dementia for the past 8 years. He does not recognize his family most of the time. He has been in memory care for the past 2 years. He is losing weight as has problem swallowing.

Other common conditions in this category:

- **Any types of Advanced Dementia**
- **Advanced Parkinson's and other advanced neurological diseases**
- **Late effect of Stroke**

Section 3-A: Medical Care Preferences

Permanently Unconscious

I am not conscious.

AND

My health care providers believe it very unlikely I will ever regain consciousness.

Page 5 of AD form

Martha, Age 62

Martha was in an auto accident and has since been unconscious. Her doctors have determined that she is in a persistent vegetative state, and it is highly unlikely she will ever meaningfully interact with others or be able to care for herself.

Other common conditions in this category:

- **Any types of severe head injuries**
- **Severe Stroke**

Section 3-B:What Matters to Me and for Me

- ✓Only applies when you are in a terminal condition.
- ✓Communicates things very important and valuable **to** and **for** you in life:
  - **important *<u>to you</u>* about your life (Value)**
  - **important *<u>for you</u>* as you live your life (Needs)**
- ✓You can specify circumstances under which you would ***not*** want to receive life-sustaining measures.
- ✓Free text sections, multiple choices.

Page 6-7 of AD form

I do not want life-sustaining procedures if I can not be supported and be able to engage in the following ways:

Initial all that apply

_____ Express my needs

_____ Be free from long-term severe pain and suffering

_____ Know who I am and who I am with

_____ Live without being hooked up to mechanical life support

_____ Participate in activities that have meaning to me, such as:

Section 3-C.My Belief System

Page 8 of AD form

- It is a narrative section and optional.
- Your belief systems can give you strength while experiencing serious illness and/or terminal conditions
- Any topics of particularly individual importance

(e.g. faith community, rituals, sacraments, healing practices, etc.)

Section 4:More Information

~you can add extra information to guide your care~

A. Life and Values. Share more about your life, values and wishes.

B. Place of Care. Express your ***wishes***, given a choice of where you can receive care. (e.g. a hospital, a nursing home, your home)

C. Other. **You may attach documents**

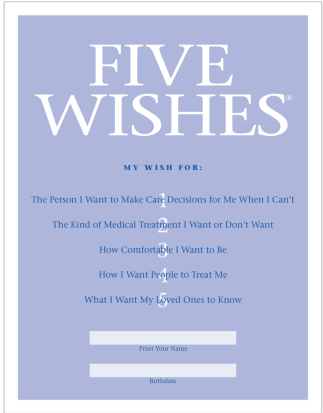
Documents you write expressing your values:

- AD from different states,
- Forms which shared your values (e.g., FIVE WISHES, Your Conversation starter Kits)
- Any other information that you wish to share

D. Inform Others. You can list people who your HCR and providers should speak with regarding your health status and care.

** If you have individual(s) you do NOT want to be involved in your care, you can put the name(s) and relation(s) under 'C'.*

Page 8-9 of AD form

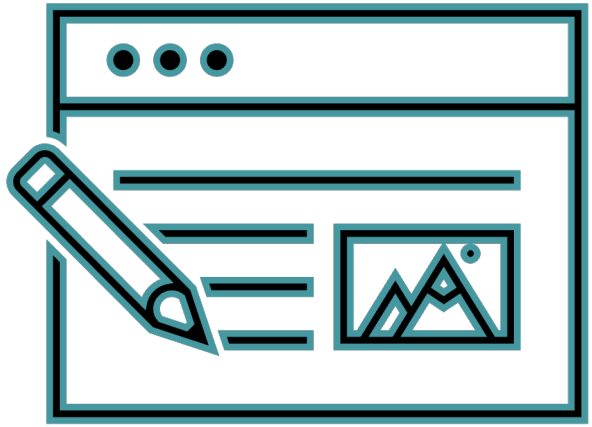


Section 5-7:
Signatures, Witnesses or Notary, Acceptance by Health Care Representative

Page 9-11 of AD form

- ✓ For the form to be valid, it must be signed, dated, and witnessed by either a **Notary or two witnesses,** other than the health care representative or your health care provider(s).
- ✓ Heath Care Representatives can accept in any mode that indicates acceptance. As soon as the Health Care Representative **has accepted** the appointment by any means*, it is valid.

*by phone, text message, email, conversation, etc.



User's Guide

Emphasizes having continued conversations with the Health Care Representative

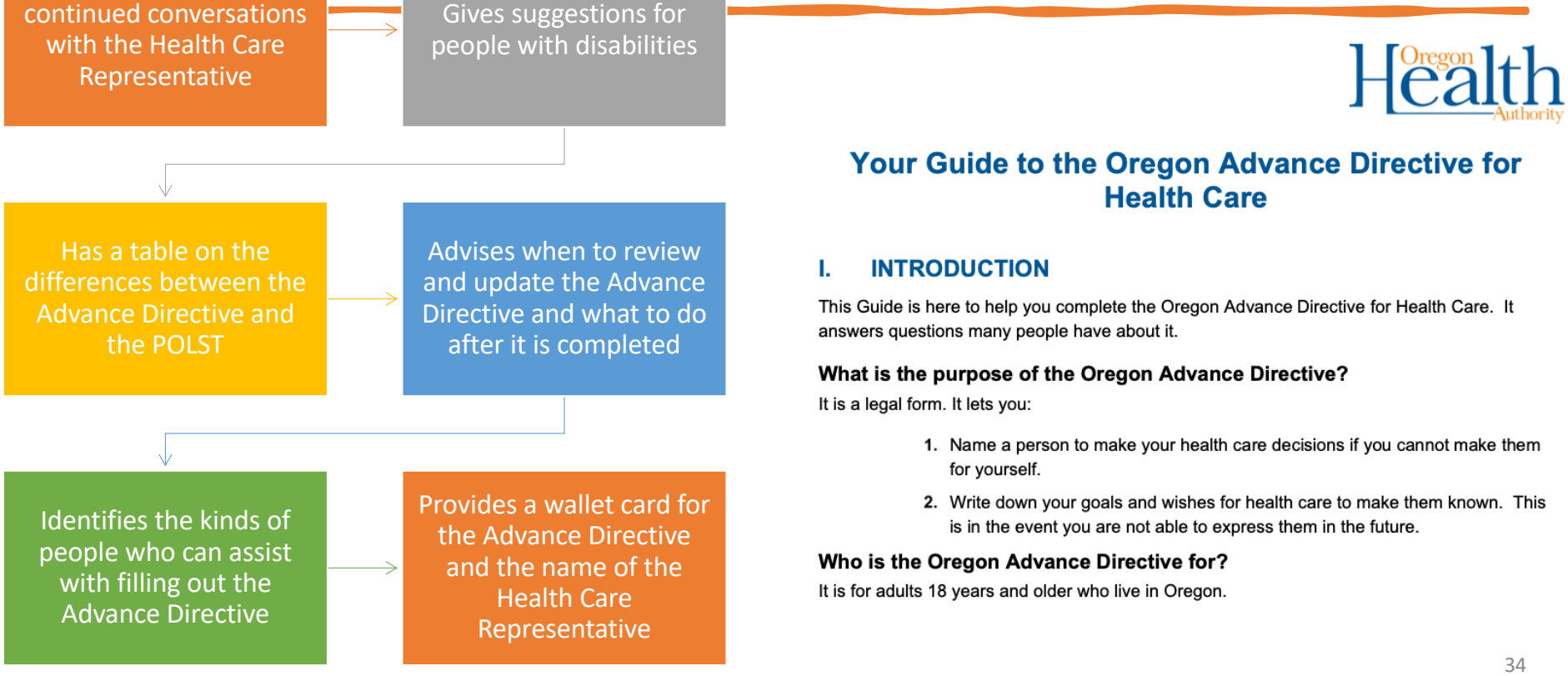
Gives suggestions for people with disabilities

Has a table on the differences between the Advance Directive and the POLST

Advises when to review and update the Advance Directive and what to do after it is completed

Identifies the kinds of people who can assist with filling out the Advance Directive

Provides a wallet card for the Advance Directive and the name of the Health Care Representative



Oregon Health Authority

Your Guide to the Oregon Advance Directive for Health Care

I. INTRODUCTION

This Guide is here to help you complete the Oregon Advance Directive for Health Care. It answers questions many people have about it.

What is the purpose of the Oregon Advance Directive?

It is a legal form. It lets you:

1. Name a person to make your health care decisions if you cannot make them for yourself.
2. Write down your goals and wishes for health care to make them known. This is in the event you are not able to express them in the future.

Who is the Oregon Advance Directive for?

It is for adults 18 years and older who live in Oregon.

When to Update your Advance Directive:

... after you experience any of the “Six D’s”

- **D**ecade: At each new decade of your life
- **D**eath: When a loved one or a health care representative dies
- **D**isagreement: When your health care representative does not agree with your wishes
- **D**ivorce: If you separate from a spouse or domestic partner who is your Advance Directive representative, you must complete a new Advance Directive EVEN IF you want them to continue serving as your representative
- **D**iagnosis: When you are diagnosed with a serious illness or **D**ementia (in early stage)
- **D**ecline: When your health declines or you can no longer live on your own

OFFICE OF THE DIRECTOR
Office of the State Public Health Director

Oregon Healt

Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- . Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care re resentative. This will allow them to make decisions that reflect your wishes. It is recom mended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

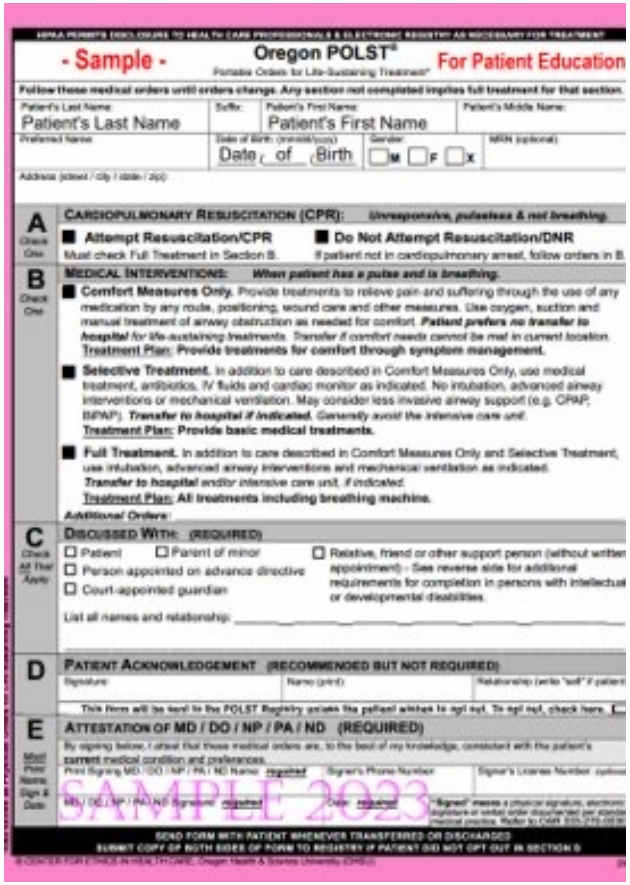
- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in 127.663. You can find more information about the POLST in Your Guide to the Oregon vance Directive.

This form may be used in Oregon to choose a person to make health care decisions you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not hav effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority s forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive v replace any older directive.



- Sample - Oregon POLST® For Patient Education

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

Patient's Last Name | Suffix | Patient's First Name | Patient's Middle Name

Preferred Name | Date of Birth | Gender M F X | MRN (optional)

Address (street / city / state / zip)

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

■ Attempt Resuscitation/CPR — Must check Full Treatment in Section B.

■ Do Not Attempt Resuscitation/DNR — If patient not in cardiopulmonary arrest, follow orders in B.

B MEDICAL INTERVENTIONS: *When patient has a 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.**

■ **Selective 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 Selective 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 DISCUSSED WITH: (REQUIRED)

☐ Patient ☐ Parent of minor ☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.
☐ Person appointed on advance directive
☐ Court-appointed guardian

List all names and relationship: _____

D PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)

Signature | Name (print) | Relationship (write "self" if patient)

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E ATTESTATION OF MD / DO / NP / PA / ND (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 / ND Name: required | Signer's Phone Number | Signer's License Number (optional)

MD / DO / NP / PA / ND Signature: required | Date: required

"Signed" means a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-745-0010(8)

SAMPLE 2023

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 D

AD
vs
POLST

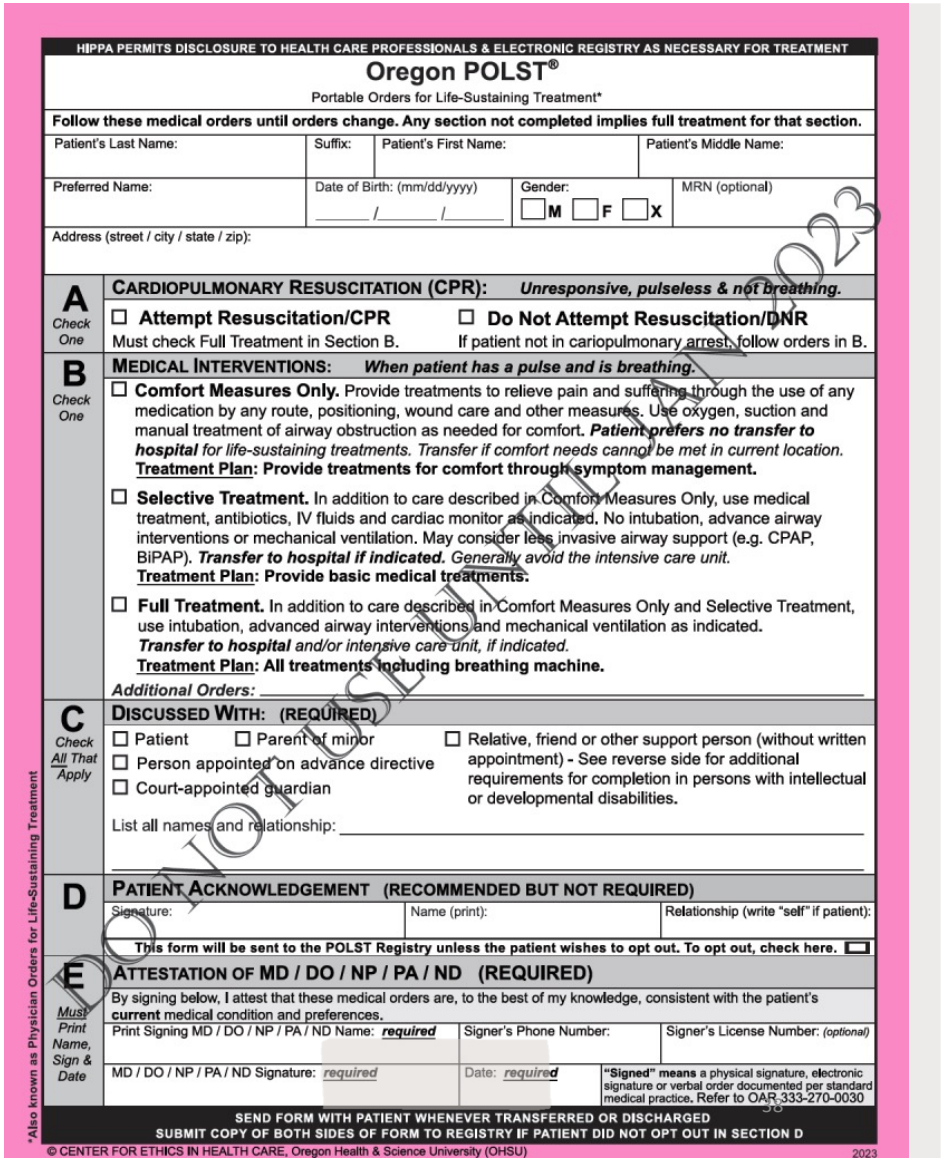
POLST

≠

AD

Portable Orders for Life-Sustaining Treatment

- A medical order written by health care providers (Physicians, Nurse Practitioners, Physicians Assistants, Naturopathic physician)
- **ONLY** for people with serious progressive illness: Advanced Organ Failure or Advanced Cancer or Advanced Dementia or Advanced Frailty or Advanced age **AND** want to set limits on medical treatments.
- Intended to be followed by Emergency Medical Technicians (EMT), or other emergency medical personnel, as an **out-of-hospital** medical order set.



HIPPA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

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

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:

Preferred Name:	Date of Birth: (mm/dd/yyyy)	Gender:	MRN (optional)
	____/____/____	☐M ☐F ☐X	

Address (street / city / state / zip):

A *Check One*

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

☐ **Attempt Resuscitation/CPR** — Must check Full Treatment in Section B.

☐ **Do Not Attempt Resuscitation/DNR** — If patient not in cariopulmonary arrest, follow orders in B.

B *Check One*

MEDICAL INTERVENTIONS: ***When patient has a 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.

☐ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advance 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 Selective 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 All That Apply*

DISCUSSED WITH: (REQUIRED)

☐ Patient ☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.

List all names and relationship: _____

D

PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)

Signature:	Name (print):	Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E *Must Print Name, Sign & Date*

ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)

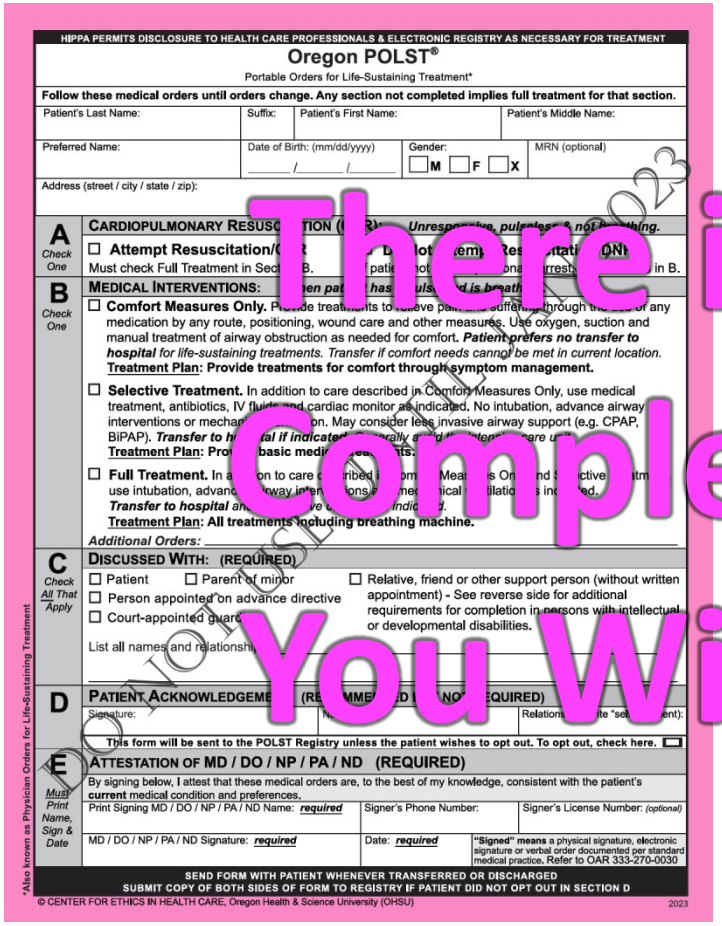
By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: ***required***	Signer's Phone Number:	Signer's License Number: *(optional)*
MD / DO / NP / PA / ND Signature: *required*	Date: *required*	**"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

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 D

*Also known as Physician Orders for Life-Sustaining Treatment

A Preemptive Medical Order Outlining Specific Choices



HIPPA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

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

Patient's Last Name: | Suffix: | Patient's First Name: | Patient's Middle Name:

Preferred Name: | Date of Birth: (mm/dd/yyyy) | Gender: ☐M ☐F ☐X | MRN (optional)

Address (street / city / state / zip):

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

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

Must check Full Treatment in Section B.

B Check One — **MEDICAL INTERVENTIONS:** *When 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.

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

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use all medical treatment, advanced airway interventions, mechanical ventilation as indicated. ***Transfer to hospital*** and use intensive care when indicated.
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C Check All That Apply — **DISCUSSED WITH: (REQUIRED)**

☐ Patient ☐ Parent of minor ☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.
☐ Person appointed on advance directive
☐ Court-appointed guardian

List all names and relationships: _____

D — **PATIENT ACKNOWLEDGEMENT (REQUIRED IF PATIENT IS CAPABLE AND NOT REQUIRED)**

Signature: | Printed Name: | Relationship (if not patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E Must Print Name, Sign & Date — **ATTESTATION OF MD / DO / NP / PA / ND (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 / ND Name: ***required*** | Signer's Phone Number: | Signer's License Number: *(optional)*

MD / DO / NP / PA / ND Signature: ***required*** | Date: ***required*** | **"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

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 D

*Also known as Physician Orders for Life-Sustaining Treatment

There is No Need to Complete a POLST, if You Wish to Recieve "CPR"

A. Cardiopulmonary Resuscitation (CPR)

- ❑**Attempt Resuscitation/CPR** → Do it
- ❑**Do Not Attempt Resuscitation/DNR** → Do not do it

B. Medical Interventions

- ❑**Comfort Measures Only**

  Symptom management for comfort, usually no hospital care
- ❑**Selective Treatment**

  Basic medical treatments, including hospital care
- ❑**Full Treatment**

  All treatments available

ACP related Documents	Advance Directive	POLST
Who is it for?	Anyone 18 years old and above, who has capacity	Patients who are old or frail or seriously ill AND who may NOT want all possible treatments
What type of document?	Legal document	Medical order
Can I use it to appoint my surrogate?	Yes	No
Who fills it out?	Individual	Health care provider (e.g., doctor) after discussion with patient or SDM**
Who signs it?	Individual, HCR*, and either 2 witnesses or a Notary Public	Health care provider (with individual or SDM**'s input)
Do I need a lawyer?	No	No
Who keeps the form?	Individual, HCR*, and health care provider	Individual, health care provider, and in the electronic Oregon POLST registry
Can I change the form ?	Yes (as long as you have capacity)	Yes
What if there is a medical emergency and I cannot speak for myself?	Medical care team will try to honor your wishes (with or w/o) HCR*	Medical care team obtains the POLST and follows the instruction
Can Surrogates create/sign the form?	No	Yes, with a health care provider
Can emergency responders use it?	No	Yes
Comments *HCR: Health care representative **SDM: Surrogate decision maker	Not always easy to find the document in different health care settings (Needs to provide copies for each HCP in different settings)	Upon hospital admission CODE status will be discussed. DNR on POLST is not automatic DNR in a hospital setting

Advance Care Planning

≠

AD/POLST Completion


My Journey in
Advance Care Planning
Healthy
Less Healthy and/or Older
Name Surrogate Decision Maker
Complete Advance Directive
Complete POLST
EOL Care
Decisions
Ongoing Conversations and Dialogues
with
Your Loved Ones and Medical Team

The Quintuple Aims of Medicine