HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN/PA. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person's Name (last, first, middle) Date of Birth

Print Person's Address

A

GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B

MEDICAL INTERVENTIONS *Person is breathing and/or has a pulse*

❒ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.

❒ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.

❒ Transfer to hospital for medical interventions. ❒ Transfer to hospital only if comfort needs cannot be met in current location.

❒ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION *Always offer food/fluids by mouth, if feasible and desired*

❑ No artificial nutrition ❑ Long-term artificial nutrition ❑ Defined trial period of artificial nutrition

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

❑ Attempt resuscitation/CPR

❑ Do not attempt resuscitation/DNAR
Allow Natural Death

AIRWAY MANAGEMENT *Person is in respiratory distress with a pulse*

❑ Intubate/use artificial ventilation as needed

❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort

❑ Additional Order (for example defined trial period of mechanical ventilation)

_____

_____

E

If I lose my decision-making capacity, I authorize my surrogate decision-maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN/PA in keeping with my goals: ❑ Yes ❑ No

F

SIGNATURES

I have discussed this information with my physician/APN/PA

_____
Print Name

_____
Signature

❑ Person Named Above ❑ Spouse/Civil Union Partner

❑ Health Care Representative/ Legal Guardian ❑ Parent of Minor

❑ Other Surrogate

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

_____
PRINT - Physician/APN/PA Name Phone Number

_____
Physician/APN/PA Signature (Mandatory) Date/Time

_____
Professional License Number

SURROGATE INFORMATION

Surrogate listed here is the healthcare representative previously identified in an advance directive: ❑ Yes ❑ No ❑ Unknown

_____
Print Name of Surrogate Phone Number

_____
Print Surrogate Address

■ **Surrogate listed is only authorized to change this form if "yes" is checked in Section E above.**

SEND ORIGINAL FORM WITH PERSON, WHENEVER TRANSFERRED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

DIRECTIONS FOR HEALTHCARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician, advance practice nurse or physician assistant.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially 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 – *An individual with decision-making capacity can always modify/void a POLST at any time.*

- A surrogate, if authorized in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision-maker, if authorized on this form to do so, may request to modify the orders based on the known desires of the person or, if unknown, the person's best interests.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

Section A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but are not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Activities such as eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis to enable the person to set realistic goals.

Section B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

Section C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

Section D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

Section E

This section is applicable in situations where the person has decision-making capacity when the POLST form is completed. A surrogate may only void or modify an existing POLST form, or execute a new one, if authorized in this section by the person.

Section F

POLST must be signed by a practitioner, meaning a physician, APN or PA, to be valid. Verbal orders are acceptable with follow-up signature by the physician/APN/PA in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.