**Montana Provider Orders for Life-Sustaining Treatment (POLST)**

- **FIRST** follow these orders, **THEN** contact Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- Completing a POLST is **ALWAYS VOLUNTARY**.

In preparing these orders, inquire if the patient has a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.

### A. Cardiopulmonary Resuscitation (CPR)

- **YES CPR: Attempt Resuscitation**
- **NO CPR: Do Not Attempt Resuscitation (DNAR)/Allow Natural Death (AND)**

**NOTE:** Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B. If not in cardiopulmonary arrest, follow orders in Section B.

### B. Medical Interventions

- **Full Treatment**—primary goal to prolong life by all medically effective means:
  - In addition to treatments described below in "Selective Treatment" and "Comfort-focused Treatment," use intubation, advanced airway interventions, mechanical ventilation, and cardioversion, as indicated. Transfer to hospital, if indicated. Includes intensive care.

- **Selective Treatment**—goal to treat medical conditions while avoiding burdensome measures:
  - In addition to treatment described below in "Comfort-focused Treatment," use IV antibiotics and IV fluids, as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

- **Comfort-focused Treatment**—primary goal to maximize comfort:
  - Relieve pain and suffering with medication by any route, as needed; use oxygen, suctioning, and manual treatment of airway obstruction, if indicated. Do not use treatments listed in "Full Treatment" and "Selective Treatment" above, unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

### C. Artificially Administered Nutrition

- **If feasible, always offer food & water by mouth.**

- **Artificial nutrition by tube**—long term/permanent, if indicated.
- **Artificial nutrition by tube**—short term/temporary only.
- **No artificial nutrition by tube**.
- **No decision has been made**.

### D. Discussed With (check all that apply):

- **Patient**
- **Legal guardian**
- **Other (Name & Relationship):**

### Signatures of Provider AND Patient, Surrogate, Medical Power of Attorney, and Legal Guardian (Mandatory)

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate. Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Power of Attorney, CPR order, Living Will, or other Advance Directive (attach if available).

### Signature of Provider

My signature below indicates to the best of my knowledge that these orders are consistent with the patient preferences.

Name of Person Preparing Form | Phone number of Preparer | Date Performed
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Physician / APRN / PA Signature (Mandatory) | Print Physician / APRN / PA Name | Date Signed (Mandatory)

Revised September 2019