**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**
**HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY**

# 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.**

| Legal Last Name | |
|---|---|
| Legal First Name/Middle Name | |
| Date of Birth | |

***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** — Check one box only

**CARDIOPULMONARY RESUSCITATION (CPR)** ***Person has NO pulse and is not breathing.***

☐ **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 When not in cardiopulmonary arrest, follow orders in Section B.*

**B** — Check one box only

**MEDICAL INTERVENTIONS** ***Person HAS a pulse and is breathing.***

☐ **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** — Check one box only

**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
☐ Medical Power of Attorney ☐ 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).

| *Patient/Legal Decision Maker Signature (Mandatory)* | *Name (Print)* | *Relationship/ Decision maker status (Write "self" if patient)* | *Date Signed (Mandatory)* |
|---|---|---|---|
| | | | |

***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* |
|---|---|---|
| | | |
| *Physician / APRN / PA Signature (Mandatory)* | *Print Physician / APRN / PA Name* | *Date Signed (Mandatory)* |
| | | |