County of Santa Cruz

HEALTH SERVICES AGENCY

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EMERGENCY MEDICAL SERVICES PROGRAM

Policy No. 1190
April 1, 2012

Emergency Medical Services Program

Approved

Medical Director

Subject: GUIDELINES FOR EMS PERSONNEL REGARDING DO NOT RESUSCITATE DNR) ORDERS/DIRECTIVES

I. Authority and References:

A. California EMS Authority Publication #111, Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Directives, March 1993, second edition.
B. California Probate Code § 4600 and following on Advanced Directives.
C. California Probate Code Section 4780 - 4785

II. Purpose:

To establish criteria for EMS field personnel in Santa Cruz County to withhold resuscitative measures.

This policy applies to both adult and pediatric patients.

III. Definitions:

A. Do not resuscitate (DNR) means that no resuscitative measures are performed on a patient. Resuscitative measures include: (i) chest compressions, (ii) defibrillation, (iii) assisted ventilation, (iv) endotracheal intubation, and (v) cardiotonic drugs. Patients shall receive palliative treatment other than resuscitative measures (e.g., for airway obstruction, pain, dyspnea, major hemorrhage, etc.), as appropriate and in accordance with Santa Cruz County EMS Agency BLS and ALS treatment protocols and policies.

B. Absent vital signs: Absence of respirations and absence of carotid pulse.

C. Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form: Form approved by the California Emergency Medical Services Authority (EMSA) and the California Medical Association (CMA) that permits patients to request that EMS not perform resuscitative measures on them. (See Section V.)

D. Physician Orders for Life-Sustaining Treatment (POLST): This form stipulates levels of care to be delivered to the patient. It is signed by the patient/patient's representative and the patient's physician. POLST stipulates whether or not resuscitation should be performed in the event of cardiac arrest, and, if the patient is alive, the level of care to be provided. For the purposes of prehospital medical care provision, only Sections A and B needs to be evaluated.

E. DNR Medallion: Medal or permanently imprinted insignia worn by a patient which has been manufactured and distributed in accordance with EMSA and CMA DNR requirements. The medallion/medal is imprinted with the words "Do Not Resuscitate, EMS." (See Section V.)

IV. Other Advance Health Care Directives

A. Another legal instrument, which may be encountered, is the California Durable Power of Attorney for Health Care (DPAHC) found in Civil Code Sections 2430-2445. This document allows individuals to appoint an "attorney-in-fact" to make health care decisions for them if they become incapacitated. (Note that the attorney-in-fact is prohibited from consenting to certain treatments, including placement in a mental health facility, convulsive therapy, psychosurgery, sterilization and abortion.) The document also allows written specification of what types of treatment or the intensity of care (including a DNR order) an individual would desire if they were unable to make decisions for themselves. Decisions by the attorney-in-fact must be within the limits set by the individual, if any, when they complete the DPAHC.

The DPAHC is four (4) pages long, although not all sections must be completed. Health care providers, including emergency responders, respecting the decisions of the attorney-in-fact or written instructions in the DPAHC are provided immunity from criminal prosecution, civil liability, or professional disciplinary action.

Providers may be directed to respect the decisions made by an attorney-in-fact at the scene of an emergency when the patient is unable to make decisions for her/himself. Providers may respect directions found written in the DPAHC regarding withholding or providing resuscitation. Written information in the DPAHC gives health care providers direction as to the patient's wishes and may be valuable in assessing whether to proceed with resuscitation.

B. "Living Wills": There are a variety of " living wills" available from many sources. While these may communicate to the provider some sense of the patient's wishes regarding resuscitation, the wide variety of these documents, and the inability to confirm the legitimacy of the orders, make them unsuitable for emergency use without prior confirmation. However, a Base Hospital may elect to use a living will in guiding a patient's therapy. When in doubt, the provider should contact the Base Hospital.

C. "Declaration": Another document is the "Declaration" found in the California Natural Death Act (Health and Safety Code Sections 7185-7194.5). This instrument is a declaration to physicians by adult patients directing the withholding or withdrawal of life sustaining procedures in a terminal condition or permanent unconscious state. The directive only applies to incurable and irreversible conditions that "without the administration of life-sustaining treatment, will within reasonable medical judgment, result in death within a relatively short time." Two physicians must examine the patient and certify his/her condition in writing, the patient cannot be pregnant at the time the

declaration is honored, and the instrument must be witnessed by two individuals who are subject to certain limitations. Life-sustaining treatment includes any medical procedure or intervention, including hydration and nutrition that serves only to prolong the process of dying or an irreversible coma or persistent vegetative state. The Declaration should be viewed largely as a directive to the physician and other health care providers regarding the patient's wishes; however, it is not as suitable for use in prehospital care as standardized DNR directives, or even the DPAHC.

V. Attachments

Attachment A: California Emergency Medical Services Authority/California Medical Association statewide prehospital DNR Form. NOTE: SAMPLE ONLY. THIS IS NOT A VALID FORM.

Attachment B: California Emergency Medical Services Authority/California Medical Association statewide prehospital DNR Form - Spanish instructions version. NOTE: SAMPLE ONLY. THIS IS NOT A VALID FORM.

Attachment C: List of DNR medallion manufacturers approved by the California EMS Authority.

Attachment D: California Medical Association form; Durable Power of Attorney for Health Care Decisions, 1996.

Attachment E: 2014 California POLST Form

SAMPLE

ATTACHMENT A
NOT FOR ACTUAL USE
EMSA/CMA DNR FORM

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

CALIFORNIA MEDICAL ASSOCIATION

PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in **prehospital settings** -- i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decision-maker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a health care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The **white copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion — see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **goldenrod copy** of the form should be retained by the physician and made part of the patient's permanent medical record.

The pink copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCATION

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.

ATTACHMENT B: (SAMPLE INSTRUCTIONS ONLY, NOT A VALID FORM)

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

SERVICIOS MÉDICOS DE EMERGENCIA
FORMA PARA PREVENIR UN INTENTO DE RESUCITACIÓN (DNR) PREVIO A UNA HOSPITALIZACIÓN

Instrucciones anticipadas para limitar el alcance de la atención médica de emergencia

Yo, _____ , solicito atención médica de emergencia limitada como se describe en esta forma.

Entiendo que la forma para prevenir un intento de resucitación (DNR) significa que si mi corazón dejara de latir o si yo dejara de respirar, no se iniciará ningún procedimiento médico para ayudarme a volver a respirar o para que mi corazón funcione de nuevo.

Entiendo que esta decisión no me previene de recibir otro tipo de atención médica de emergencia de parte del personal de servicios médicos de emergencia antes de una hospitalización ni de la atención médica que reciba de un médico antes de mi muerte.

Entiendo que puedo cambiar estas instrucciones en cualquier momento destruyendo esta forma y todas las medallas "DNR".

Doy permiso para que esta forma sea distribuida al personal de atención médica de emergencia, médicos, enfermeras(os) y a todo el personal que sea necesario para cumplir con estas instrucciones.

Por la presente indico mi conformidad con la orden de Prevenir un intento de resucitación (DNR).

Al firmar esta forma, el representante atesta que esta solicitud para no realizar un intento de resucitación concuerda con los deseos expresados de la persona sobre quien trata esta forma y es para el bien de la misma.

_____ _____

Firma del paciente o representante Fecha

_____

Relación del representante y el paciente

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____

Physician Signature Date

_____ _____

Print Name Telephone

_____

Address

ESTE DOCUMENTO NO SERÁ ACEPTADO SI EXISTE ALGUNA ENMIENDA O ALTERACIÓN EN EL MISMO

Copia blanca: Para el paciente. Copia amarilla: Para la historia médica del paciente. Copia rosada: Para solicitar una medalla DNR.

SAMPLE - THIS IS NOT A VALID FORM

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

CALIFORNIA MEDICAL ASSOCIATION

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept by patient
Yellow Copy: To be kept in patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

ATTACHMENT D

California Medical Association

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(California Probate Code Sections 4600-4753)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney by appointing the person designated below to make health care decisions for me as allowed by Sections 4600 to 4753, inclusive, of the California Probate Code. This power of attorney shall not be affected by my subsequent incapacity. I hereby revoke any prior durable power of attorney for health care. I am a California resident who is at least 18 years old, of sound mind, and acting of my own free will.

2. APPOINTMENT OF HEALTH CARE AGENT

(Fill in below the name, address and telephone number of the person you wish to make health care decisions for you if you become incapacitated. You should make sure that this person agrees to accept this responsibility. The following may not serve as your agent: (1) your treating health care provider; (2) an operator of a community care facility or residential care facility for the elderly; or (3) an employee of your treating health care provider, a community care facility, or a residential care facility for the elderly, unless that employee is related to you by blood, marriage or adoption, or unless you are also an employee of the same treating provider or facility. If you are a conservatee under the Lanterman-Petris-Short Act (the law governing involuntary commitment to a mental health facility) and you wish to appoint your conservator as your agent, you must consult a lawyer, who must sign and attach a special declaration for this document to be valid.)

I, _____, hereby appoint:
(insert your name)

Name _____

ress _____

ork Telephone (_____) _____ Home Telephone (_____) _____

as my agent (attorney-in-fact) to make health care decisions for me as authorized in this document. I understand that this power of attorney will be effective for an indefinite period of time unless I revoke it or limit its duration below.

(Optional) This power of attorney shall expire on the following date: _____.

3. AUTHORITY OF AGENT

If I become incapable of giving informed consent to health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any statements of desires or limitations set forth below. Unless I have limited my agent's authority in this document, that authority shall include the right to consent, refuse consent, or withdraw consent to any medical care, treatment, service, or procedure; to receive and to consent to the release of medical information; to authorize an autopsy to determine the cause of my death; to make a gift of all part of my body; and to direct the disposition of my remains, subject to any instructions I have given in a written contract for funeral services, my will or by some other method. I understand that, by law, my agent may not consent to any of the following: commitment to a mental health treatment facility, convulsive treatment, psychosurgery, sterilization or abortion.

4. MEDICAL TREATMENT DESIRES AND LIMITATIONS (OPTIONAL)

(Your agent must make health care decisions that are consistent with your known desires. You may, but are not required to, state your desires about the kinds of medical care you do or do not want to receive, including your desires concerning life support if you are seriously ill. If you do not want your agent to have the authority to make certain decisions, you must write a statement to that effect in the space provided below; otherwise, your agent will have the broad powers to make health care decisions for you that are outlined in paragraph 3 above. In either case, it is important that you discuss your health care desires with the person you appoint as your agent and with your doctor(s).

(Following is a general statement about withholding and removal of life-sustaining treatment. If the statement accurately reflects your desires, you may initial it. If you wish to add to it or to write your own statement instead, you may do so in the space provided.)

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of the treatment outweigh the expected benefits. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and the quality of my life, as well as the extent of the possible prolongation of my life.

If this statement reflects your desires, initial here: _____

her or additional statements of medical treatment desires and limitations: _____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statements. Each additional page must be dated and signed at the same time you date and sign this document.)

5. APPOINTMENT OF ALTERNATE AGENTS (OPTIONAL)

(You may appoint alternate agents to make health care decisions for you in case the person you appointed in Paragraph 2 is unable or unwilling to do so.)

If the person named as my agent in Paragraph 2 is not available or willing to make health care decisions for me as authorized in this document, I appoint the following persons to do so, listed in the order they should be asked:

First Alternate Agent: Name _____

Address _____

Work Telephone (_____) _____ Home Telephone (_____) _____

Second Alternate Agent: Name _____

Address _____

ork Telephone (_____) _____ Home Telephone (_____) _____

USE OF COPIES

I hereby authorize that photocopies of this document can be relied upon by my agent and others as though they were originals.

ATTACHMENT D

DATE AND SIGNATURE OF PRINCIPAL

(You must date and sign this power of attorney)

I sign my name to this Durable Power of Attorney for Health Care at _____, _____
(City) *(State)*

on _____. _____
(Date) *(Signature of Principal)*

STATEMENT OF WITNESSES

(This power of attorney will not be valid for making health care decisions unless it is either (1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature or (2) acknowledged before a notary public in California. If you elect to use witnesses rather than a notary public, the law provides that none of the following may be used as witnesses: (1) the persons you have appointed as your agent and alternate agents; (2) your health care provider or an employee of your health care provider; or (3) an operator or employee of an operator of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to you by blood, marriage or adoption, or be named in your will.

(SPECIAL RULES FOR SKILLED NURSING FACILITY RESIDENTS: If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign both the statement of witnesses below and the declaration on the following page. You must also have a second qualified witness sign below or have this document acknowledged before a notary public.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me to be the principal, or that the identity of the principal was proved to me by convincing evidence;* that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence; that I am not the person appointed as attorney in fact by this document; and that I am not the principal's health care provider, an employee of the principal's health care provider, the operator of a community care facility or a residential care facility for the elderly, nor an employee of an operator of a community care facility or residential care facility for the elderly.

First Witness: Signature _____

Print name _____

Date _____

Residence Address _____

Second Witness: Signature _____

Print name _____

Date _____

Residence Address _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION)

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

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e law allows one or more of the following forms of identification as convincing evidence of identity: a California driver's license or identification card or .S. passport that is current or has been issued within five years, or any of the following if the document is current or has been issued within five years, contains photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number: a foreign passport that has been amped by the U.S. Immigration and Naturalization Service; a driver's license issued by another state or by an authorized Canadian or Mexican agency; or an identification card issued by another state or by any branch of the U.S. armed forces. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

SPECIAL REQUIREMENT: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses above and must also sign the following declaration.)

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by subdivision (e) of Probate Code Section 4701.

Signature: _____ Address: _____

Print Name: _____ _____

Date: _____ _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(Acknowledgment before a notary public is not required if you have elected to have two qualified witnesses sign above. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses on page 3 and the Statement of Patient Advocate or Ombudsman above)

State of California)

)ss.

County of _____)

On this _____ day of _____, in the year _____,

before me, _____,

(here insert name and title of the officer)

personally appeared _____

(here insert name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____

(Signature of Notary Public)

NOTARY SEAL

COPIES

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY. YOU SHOULD KEEP THE COMPLETED ORIGINAL AND GIVE PHOTOCOPIES OF THE COMPLETED ORIGINAL TO (1) YOUR AGENT AND ALTERNATE AGENTS, (2) YOUR PERSONAL PHYSICIAN, AND (3) MEMBERS OF YOUR FAMILY AND ANY OTHER PERSONS WHO MIGHT BE CALLED IN THE EVENT OF A MEDICAL EMERGENCY. THE LAW PERMITS THAT PHOTOCOPIES OF THE COMPLETED DOCUMENT CAN BE RELIED UPON AS THOUGH THEY WERE ORIGINALS.

Attachment E

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Cardiopulmonary Resuscitation (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Medical Interventions: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — Information and Signatures:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Healthcare Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: **M F**

Healthcare Provider Assisting with Form Preparation ☐ N/A if POLST is completed by signing physician		
Name:	Title:	Phone Number:

Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone Number:

Directions for Healthcare Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED