PAIST		RST NAME / MIDDLE NAM	ΛΕ/INITIAL	
rtable Orders for Life-Sustaining Treatment articipating Program of National POLST	DATE OF BIRTH	/	GENDER (optional)	PRONOUNS (optional)
This is a medical order. It must		n a medical professiona ee page 2 for complete instr		is always voluntary.
DICAL CONDITIONS/INDIVIDUAL GOAL	LS:		AGENCY INFO	/ PHONE (if applicable)
Use of Cardiopulmonary	y Resuscitation	(CPR): When the indiv	vidual has NO pulse and	is not breathing.
☐ YES – Attempt Resuscit☐ NO – Do Not Attempt R				en not in cardiopulmonary arrest, go to Section B.
interventions, mechanical vertransfer to hospital if indicate  SELECTIVE TREATMENT - Prossible. Use medical treatre invasive airway support (e.g., Transfer to hospital if indicate by any route as needed. Use Individual prefers no transfer provide adequate comfort.  Additional orders (e.g., blood)	ed. Includes intensive Primary goal is treament, IV fluids and m , CPAP, BiPAP, high-fled. Avoid intensive ca TMENT – Primary goxygen, oral suction to hospital. EMS: con	care.  ting medical condition edications, and cardiac row oxygen). Includes car re if possible.  cal is maximizing combodies, and manual treatment sider contacting medical	s while avoiding invasive monitor as indicated. <b>Do r</b> e described below. fort. Relieve pain and suff of airway obstruction as re	e measures whenever not intubate. May use less fering with medication needed for comfort.
Signatures: A legal medical An individual who makes their o witnesses to verbal consent. A g signatures are allowed but not r	wn choice can ask a uardian or parent m	trusted adult to sign on ust sign for a person unc	their behalf, or clinician si Ier the age of 18. Multiple	gnature(s) can suffice as parent/decision maker
Discussed with:  ☐ Individual ☐ Parent(s) of m ☐ Guardian with health care auth ☐ Legal health care agent(s) by D ☐ Other medical decision maker	nority PPOA-HC	SIGNATURE - MD/DO PRINT - NAME OF MD/DO	D/ARNP/PA-C (mandatory)  /ARNP/PA-C (mandatory)	DATE (mandatory PHONE
SIGNATURE(S) – INDIVIDUAL OF	,	SION MAKER(S) (mandatory	RELATIONSHIP	DATE (mandatory





All copies, digital images, faxes of signed POLST forms are valid. See page 2 for preferences regarding medically assisted nutrition. For more information on POLST, visit www.wsma.org/POLST.

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY						
LAST NAME / FIRST	DATE OF BIRTH					
Additional Con	tact Information (if any)					
LEGAL MEDICAL DECIS	ION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE			
OTHER CONTACT PERSON		RELATIONSHIP	PHONE			
HEALTH CARE PROFESSIONAL COMPLETING FORM		ROLE / CREDENTIALS	PHONE			
Preference: Me	dically Assisted Nutrition (i.e., Artificia	l Nutrition)	☐ Check here if not discussed			
This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.  Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.  Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.  Preference is to avoid medically assisted nutrition.  Preference is to discuss medically assisted nutrition options, as indicated.*  Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).  *Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.  Discussed with:  Individual  Health Care Professional  Legal Medical Decision Maker						
Directions for H		TE: An individual with capacity may always or rventions, regardless of information repress				
Any incomplete section This POLST is valid in the hospital care, but valid The POLST is a set of the all previous orders.  Completing POLST  Completing POLST is as appropriate but in the Treatment choices of shared decision maked and health care profused in the polst must be signor their legal medical condition.  POLST must be signor their legal medical condition in the polst must be signor their legal medical condition.  Virtual, remote, and accordance with the see FAQ at www.wsr  POLST may be used children under the a	on of POLST implies full treatment for that section.  all care settings. It is primarily intended for out of it within health care facilities per specific policy.  Inedical orders. The most recent POLST replaces  Is soluntary for the individual; it should be offered in the required.  In socumented on this form should be the result of sking by an individual or their health care agent fessional based on the individual's preferences on.  In seed by an MD/DO/ARNP/PA-C and the individual all decision maker as determined by guardianship, relationship per 7.70.065 RCW, to be valid.  The policies of the health care facility. For examples, ma.org/POLST.  To indicate orders regarding medical care for rige of 18 with serious illness. Guardian(s)/parent(s) with the health care professionals. See FAQ at	NOTE: This form is not adequate to desagent. A separate DPOA-HC is required.  Honoring POLST  Everyone shall be treated with dignity SECTIONS A AND B:  No defibrillator should be used on a "Do Not Attempt Resuscitation."  When comfort cannot be achieved it should be transferred to a setting also of a hip fracture). This may include rown individual who desires IV fluids so "Full Treatment."  Reviewing POLST  This POLST should be reviewed when	ignate someone as a health care at to designate a health care agent.  y and respect.  In individual who has chosen In the current setting, the individual sele to provide comfort (e.g., treatment nedication by IV route for comfort. are which may prolong life. should indicate "Selective" or  ever:  the care setting or care level to another. Individual's health status.  the page and write "VOID" in large and settings, and anyone who has a			
Any incomplete section This POLST is valid in the hospital care, but valid in the POLST is a set of mall previous orders.  Completing POLST  Completing POLST  Treatment choices of shared decision maked and health care profound medical condition  POLST must be signed or their legal medical DPOA-HC, or other malling the decision maked the polst must be signed to the polst must be seen as ign the form along www.wsma.org/POL  Review of this F	on of POLST implies full treatment for that section.  all care settings. It is primarily intended for out of it within health care facilities per specific policy.  Inedical orders. The most recent POLST replaces  Is soluntary for the individual; it should be offered in the required.  In socumented on this form should be the result of sking by an individual or their health care agent fessional based on the individual's preferences on.  In seed by an MD/DO/ARNP/PA-C and the individual all decision maker as determined by guardianship, relationship per 7.70.065 RCW, to be valid.  The policies of the health care facility. For examples, ma.org/POLST.  To indicate orders regarding medical care for rige of 18 with serious illness. Guardian(s)/parent(s) with the health care professionals. See FAQ at	NOTE: This form is not adequate to desagent. A separate DPOA-HC is required.  Honoring POLST  Everyone shall be treated with dignity SECTIONS A AND B:  No defibrillator should be used on a "Do Not Attempt Resuscitation."  When comfort cannot be achieved is should be transferred to a setting also of a hip fracture). This may include refruit Treatment of dehydration is a measure An individual who desires IV fluids so "Full Treatment."  Reviewing POLST  This POLST should be reviewed when the individual is transferred from or there is a substantial change in the policy of the current POLST. Any change to the copy of the current POLST. Any change to the confirm order and preferences.	ignate someone as a health care at to designate a health care agent.  If and respect.  In individual who has chosen in the current setting, the individual ble to provide comfort (e.g., treatment nedication by IV route for comfort. are which may prolong life. hould indicate "Selective" or ever:  If e care setting or care level to another. individual's health status. The page and write "VOID" in large all settings, and anyone who has a les require a new POLST.			

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

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