NEVADA POLST (Physician Order for Life-Sustaining Treatment)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

Faxed, copied or electronic versions of a Nevada POLST are legal and valid

SIDE 1: Medical Orders

Consult this form when patient lacks decisional capacity. It is intended to be honored by any health-care provider who treats the patient in any health-care setting, including, without limitation, a residence, health care facility or the scene of a medical emergency (NRS 449.694.). A section not completed does not invalidate the rest and indicates full treatment for that section.

Last Name/First/Middle Initial		
Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
/ /		M F

Section A CPR Check one only

CARDIOPULMONARY RESUSCITATION (CPR). *Patient/resident has no pulse & is not breathing.*

☐ Attempt Resuscitation (CPR) (See Section B: Full Treatment required)

☐ Allow Natural Death (Do Not Attempt Resuscitation) If available, EMS-DNR #:_____

When not in cardiopulmonary arrest follow orders in Section B

Section B Interventions

MEDICAL INTERVENTIONS. *Patient/resident has pulse and/or is breathing.*

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

1. ☐ **Comfort Measures Only.** The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth as tolerated, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. Transfer only if comfort needs cannot be met in current location.

*Other Instructions:*_____

2. Limited Medical Interventions. Comfort measures always provided.

a. Life-Sustaining Antibiotics.

☐ No antibiotics. Use other measures to relieve symptoms
☐ Administer antibiotics by mouth as necessary
☐ Administer antibiotics IV as necessary

*Other Instructions:*_____

b. Artificially Administered Fluids and Nutrition.

☐ No feeding tube
☐ Defined trial period of feeding tube
☐ Long term feeding tube
☐ No IV fluids
☐ Defined trial period of IV fluids
☐ Long term IV fluids

*Other Instructions:*_____

c. Other Limitations of Medical Interventions.

☐ No intensive care admission
☐ No x-ray
☐ No IV (assure agreement with **a.** & **b.** above)
☐ No hyperalimentation
☐ No electrolyte or acid/base corrective measures
☐ No lab work
☐ No antiarrhythmic drugs
☐ No dialysis

*Other Instructions:*_____

3. ☐ **Full Treatment.** Includes care above plus endotracheal intubation and cardioversion.

*Additional Instructions:*_____

Section C Physician Signature

Date **(Required)**	Physician Signature **(Required)**	Physician Name (Print)
Physician Office Address	Physician Phone	Physician License No.

Send original with patient when discharged or transferred

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Patient Name:_____ **DOB:**_____

SIDE 2: Supplementary Patient Preferences

Section D Organ Donation

ORGAN DONATION

☐ I have documented on my license or state issued ID that I would like to donate my organs

*Other Instructions:*_____

Section E Advance Directive

The following documents/persons have further information regarding patient's/resident's preferences:

1. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney (DPOA) for Health Care

☐ NO ☐ YES **If no AD, skip to #2 below**

AD Registered with Secretary of State: ☐ NO ☐ YES - Registration No:_____

Other location: _____

Appointed Agent #1:_____ Telephone No:_____

Appointed Agent #2:_____ Telephone No:_____

2. If no agent appointed, another person will make decisions for you as determined by Nevada law.

3. Court-Appointed Guardian ☐ NO ☐ YES Name:_____

Telephone No: _____

Section F Signatures

Patient / Agent / Parent / Guardian (circle one) **Approval**

I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences.

Signature:_____ Date: _____

Consent for Sections A and B above were discussed with and given by:

☐ Patient ☐ Spouse ☑ Adult Child ☐ Court-Appointed Guardian

☐ Parent of Minor ☐ Health Care Agent (DPOA) ☐ Other:_____

Witnessed by (for any checked above):_____ Date:_____

Preparer's Information

Preparer's Name (print):_____ Date:_____

Signature of Person Preparing Form:_____

Section G Registry

Physician initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox. Authorization forms can be found at: www.LivingWillLockbox.com.

GENERAL INSTRUCTIONS

- Record all treatments entered on this POLST as orders in patient's chart.
- Copy POLST form for patient record.
- If orders change complete a new POLST and write VOID across this POLST.
- If no new form is completed, full treatment and resuscitation may be provided.
- Transfer or discharge patient with a current POLST form.

WHEN THIS FORM SHOULD BE REVIEWED

This form (POLST) should be reviewed periodically and if:

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

THE LASTEST VERSION OF THE POLST FORM IS AVAILABLE FROM THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH.

Send original with patient when transferred or discharged

For Internal Use