HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAIʻI

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's **current medical condition and wishes**. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.
POLST is a medical order. It is not an **Advance Directive** and is not intended to replace that document.

Patient's Last Name	
First/Middle Name	
Date of Birth	Date Form Prepared

A — Choose One

CARDIOPULMONARY RESUSCITATION (CPR): ***** Person has no pulse and is not breathing *****

☐ **Yes CPR - Attempt resuscitation** (Section B: Full Treatment **required**)

☐ **No CPR. Do Not Attempt Resuscitation** (**A**llow **N**atural **D**eath)

If patient has a pulse, follow orders in Sections **B** and **C**

B — Choose One

MEDICAL INTERVENTIONS: ***** Person has pulse and/or is breathing *****

☐ **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. Includes intensive care as needed.

☐ **Selective Treatment** – **goal of treating medical conditions and restoring function while avoiding intensive care and resuscitation.** 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 respiratory support.

☐ **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 — Choose One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube

☐ Defined trial period of artificial nutrition by tube
Goal: _____

☐ Long-term artificial nutrition by tube

Additional Orders: _____

D — Choose One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Patient or Legally Authorized Representative My signature below indicates that these orders/ resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Signature of Provider (Physician/APRN/PA licensed in the state of Hawaiʻi.) My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name	Provider Phone Number	Date

Provider Signature (required)	Provider License #

Summary of Medical Condition	Official Use Only

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Patient Name (last, first, middle)	Date of Birth	Gender

Patient's Preferred Emergency Contact (Listing a person here does not make them a Legally Authorized Representative. Only an Advance Directive or state law grants that authority.)

Name	Relationship to Patient	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

E SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS
(Legally Authorized Representative as outlined in section D)

I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.

Signature (required)	Name	Relationship

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Completing POLST
- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- The most recently completed valid POLST form supersedes all previously completed POLST forms. This form does not expire.

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

Section A:
- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "No CPR. Do Not Attempt Resuscitation"

Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort-Focused Treatment", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- A person who desires IV fluids should indicate "Selective Treatment" or "Full Treatment."

Section C:
- A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST - It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST
- A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kōkua Mau - A Movement to Improve Care

Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit **kokuamau.org/polst** to download a copy or find more POLST information. This form has been adopted by the Department of Health May 2023

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