



KŌKUA MAU
Continuous Care
 A Movement to Improve Care

POLST

Provider Orders for Life-Sustaining Treatment

Kōkua Mau is the lead agency for POLST for the State of Hawai'i. For background information for clinicians and the public, please visit: kokuamau.org/polst

You can download a copy of the official POLST form. Please note that a POLST form must be discussed with and signed by a State of Hawai'i licensed Physician, APRN (Advanced Practice Registered Nurse) or Physician Assistant (PA) to be valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAII			
<p>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.</p> <p>POLST is a medical order. It is not an Advance Directive and is not intended to replace that document.</p>		<p>Patient's Last Name</p>	<p>Date Form Prepared</p>
		<p>First/Middle Name</p>	<p>Relationship to Patient</p>
		<p>Rate of Birth</p>	<p>Phone Number</p>
<p>A CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing **</p> <p><input type="checkbox"/> Yes CPR - Attempt resuscitation (Section B: Full Treatment required)</p> <p><input type="checkbox"/> No CPR. Do Not Attempt Resuscitation - Allow Natural Death</p> <p>If patient has a pulse, follow orders in Sections B and C</p>			
<p>B MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing **</p> <p><input type="checkbox"/> 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 cardiovascular as indicated. Includes intensive care as needed.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p>Additional Orders:</p>			
<p>C ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired.</p> <p>(See Directions on next page for information on nutrition & hydration)</p> <p><input type="checkbox"/> No artificial nutrition by tube <input type="checkbox"/> Defined trial period of artificial nutrition by tube</p> <p><input type="checkbox"/> Long term artificial nutrition by tube <input type="checkbox"/> Goal:</p> <p>Additional Orders:</p>			
<p>D SIGNATURES AND SUMMARY OF MEDICAL CONDITION Discussed with:</p> <p><input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:</p> <p><input type="checkbox"/> Guardian <input type="checkbox"/> Agent designated in Power of Attorney for Healthcare <input type="checkbox"/> Patient-designated surrogate</p> <p><input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E) <input type="checkbox"/> Parent of a Minor</p> <p>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.</p> <p>Signature (required) Name (print) Relationship (write "self" if patient)</p> <p>Signature of Provider (Physician/APRN/PA licensed in the state of Hawai'i). My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.</p> <p>Front Provider Name Provider Phone Number Date</p> <p>Provider Signature (required) Provider License #</p> <p>Summary of Medical Condition Official Use Only</p>			
<p>SEND THIS 2-PAGE FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED POLST pg 1 of 2</p>			

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
<p>Patient Name (last, first, middle)</p>		<p>Date of Birth</p>	<p>Gender</p>
<p>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).</p> <p>Name Relationship to Patient Phone Number</p> <p>Health Care Professional Preparing Form Preparer Title Phone Number State Form Prepared</p>			
<p>E SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)</p> <p>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.</p> <p>Signature (required) Name Relationship</p>			
<p>DIRECTIONS FOR HEALTH CARE PROFESSIONAL</p> <p>Completing POLST</p> <ul style="list-style-type: none"> 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. <p>Using POLST - Any incomplete section of POLST implies full treatment for that section.</p> <p>Section A:</p> <ul style="list-style-type: none"> No defibrillator (including automated external defibrillators) should be used on a person who has chosen "No CPR. Do Not Attempt Resuscitation." <p>Section B:</p> <ul style="list-style-type: none"> 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." <p>Section C:</p> <ul style="list-style-type: none"> 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. <p>Reviewing POLST - It is recommended that POLST be reviewed periodically. Review is recommended when:</p> <ul style="list-style-type: none"> The person is treated 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. <p>Modifying and Voiding POLST</p> <ul style="list-style-type: none"> 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. <p>Kōkua Mau - A Movement to Improve Care</p> <p>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.</p> <p>Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • kokuamau.org</p>			
<p>SEND THIS 2-PAGE FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED POLST pg 2 of 2</p>			