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

Montana Provider Orders For Life-Sustaining Treatment (POLST)

THIS FORM MUST BE SIGNED BY A ***PHYSICIAN, PA*** *or* ***APRN*** *IN SECTION E TO BE VALID*

If any section is NOT COMPLETE:

Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male ☐ Female ☐

Section A

Select only one box

Cardiopulmonary Resuscitation: If patient does not have a pulse and/or is not breathing:

☐ **Resuscitate (Full Code)**

☐ **Do Not Resuscitate (No Code)**
(Allow Natural Death)(Comfort One)
Patient does not want any heroic or Life-saving measures.

If patient is not in cardiopulmonary arrest, follow orders found in section **B** and **C**

Section B

Select only one box

Medical Interventions: If patient has a pulse and/or is breathing:

☐ **Comfort Measures:** Please treat patient with dignity and respect. Reasonable measures are to be made to offer food and fluids by mouth and attention must be paid to hygiene. Medication, positioning, wound care, and other measures shall be used to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **EMS**: Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.

☐ **Limited Additional Interventions:** In addition to the care described above, cardiac monitoring and oral/IV medications may be provided. **EMS:** Transfer to hospital if indicated, do not perform intubation or advanced airway interventions. **Hospital:** Do not admit to Intensive Care.

☐ **Full Treatment:** In addition to the care described above, endotracheal intubation, advanced airway interventions, mechanical ventilation, defibrillation and cardioversion may be provided. **Hospital:** Admit to Intensive Care if indicated.

Other Instructions:

Section C

May select more than one

Artificial Fluids and Nutrition:

☐ Feeding tube ☐ No Feeding tube
☐ IV fluid ☐ No IV fluid

Other Instructions:

Antibiotics and Blood Products:

☐ Antibiotics ☐ No Antibiotics
☐ Blood Products ☐ No Blood Products

Other Instructions:

Section D

Advance Directives: The following documents also exist:

☐ Living Will ☐ Other ______________________________

____

Section E

Patient or **Surrogate Signature:** ____________________ Date:__________
(by signing the POLST, I agree that this POLST supersedes my living will, if the two conflict)

Print Patient or Surrogate *(person with authority under 50-9-106, MCA)*

Name:____________________ Relationship:__________

Physician/APRN/PA *(in consultation with supervising physician)* **Signature:** __________ Date:______

Print Physician/APRN/PA Name : ____________________ MT License Number: __________

Contact Phone Number: __________ **Discussed with:** ☐ Patient ☐ Spouse ☐ Other ______

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference __________

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid