# NEVADA POLST (Provider Order for Life-Sustaining Treatment)

**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY**

Complete this form only after a conversation with the patient or their representative/surrogate. POLST is for patients at risk of a life-threatening clinical event due to a life-limiting medical condition, which may include advanced frailty.

**SIDE 1: Medical Orders**

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA. For any section not completed use standard of care.

| Last Name/First/Middle Initial | | |
|---|---|---|
| Date of Birth (mm/dd/yyyy) | Last 4 SSN | Gender *X is inclusive of nonbinary* |
| / / | __ __ __ __ | M F X |

**A Choose 1**

**CARDIOPULMONARY RESUSCITATION (CPR) –** *Patient/resident has no pulse and is not breathing*

☐ Attempt Resuscitation (CPR) – Requires choice of Full Treatment in Section B
☐ Do Not Attempt Resuscitation (No CPR) - Allow Natural Death
**When not in cardiopulmonary arrest follow orders in Section B and C**

**B Choose 1**

**MEDICAL INTERVENTIONS – Check only one –** *Patient/resident has pulse and/or is breathing.*

☐ **Full Treatment.** ***Goal - sustain life by all medically effective means.***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention. Transfer to hospital/admit to ICU as indicated.

☐ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
Use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally avoid ICU.
*Other Instructions:*_____

☐ **Comfort-Focused Treatment.** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medication by *any route* as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location**.
*Other Instructions:*_____

**C**

**ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS –** *offer food & fluids by mouth if feasible or desired*

☐ Long term artificial nutrition or feeding tube ☐ No artificial nutrition or feeding tube
☐ Artificial nutrition/feeding tube trial
☐ Other instructions_____

**D Required**

**CAPACITY DETERMINATION – Completion required by Provider (Physician, APRN or PA)**

At the time of completion of this medical order, the patient:
**☐ Has decisional capacity** **☐ Lacks decisional capacity**
to understand and communicate their health care preferences for options in this medical order.

**E Bolded Items Required**

**VALIDATING SIGNATURES (Required) –** Advance Directive & Surrogate information on Side 2
Electronically signed documents are valid.

| **Date** | **Physician/APRN/PA Signature** | **Physician/APRN/PA License #** |
|---|---|---|
| | | |

| **Physician/APRN/PA Name (Printed)** | **Physician/APRN/PA Phone** |
|---|---|
| | |

**As the Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian** (circle one) 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 wishes / the patient's best-known wishes.
**Signature**_____**Print Name** _____**Date**_____

**OR** if the patient lacks capacity *and* has no known agent (DPOA-HC) or guardian, complete the following:
**Health Care Surrogate Authorization Also** *Requires Completion of Side 2, #1.C.*
**Signature**_____**Date**_____

**Send original with patient when discharged or transferred**

NEVADA FORM 021523 (Previous form #090817 is also valid)

Additional information available from Nevada POLST: www.nevadapolst.org or Nevada Division of Public and Behavioral Health

**NEVADA POLST (Provider Order for Life-Sustaining Treatment)**

**Patient Name:** _____ **DOB:** _____

## SIDE 2: Supplementary Information

**1. Representative/Surrogate Information –** The following may have further information regarding patient's preferences:

**A. Advance Directive**: AD - Living Will/Declaration ☐ NO ☐ YES

Durable Power of Attorney for Health Care (DPOA-HC) ☐ NO ☐ YES

AD filed with Living Will Lockbox: ☐ NO ☐ YES - Registration #, if known:_____

Other AD location: _____

**DPOA-HC – This information must be taken directly from the patient's valid DPOA-HC, not verbally**

Appointed agent #1: _____ Telephone No: _____

Appointed agent #2: _____ Telephone No:_____

**B. Court-Appointed Guardian** ☐ NO ☐ YES Name: _____ Phone: _____

**C. Health Care Surrogate:** Name (printed): _____

Relationship: _____ Phone: _____

**2. PREPARER:** Preparer's Name (print):_____ Title/Position (MSW, RN, etc.) _____

**3. REGISTRY:** Provider should initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Nevada Lockbox at NevadaLockbox.nv.gov

**4. ORGAN DONATION** – The POLST is *not* an authorization for organ donation, please refer to the patient's state-issued ID

**Terms of Use**

- The POLST is ALWAYS VOLUNTARY and may not be mandated for a patient.
- The POLST is intended for the seriously ill or frail, and for whom a health care professional would not be surprised if they died within a year; others should be offered an AD with DPOA-HC designation.
- This medical order is to be honored in all care settings. In-patient order sets should reflect these POLST orders. The POLST is to be followed until voided or replaced by new orders.
- Photocopied, faxed or electronic versions are valid as long as required signatures (Section E) are included.
- When comfort cannot be achieved in the current setting, the patient should be transferred to a setting able to provide comfort.

**Completing a POLST**

- If a patient lacks decisional capacity, their DPOA-HC, legal guardian or parent of a minor may complete a POLST. If the patient has no such representative *and* lacks decisional capacity, then a surrogate may complete a POLST for the patient. Surrogates are, in order of authority, a spouse, the majority of adult child(ren), parent(s), a majority of adult sibling(s), the nearest other adult relative of the patient by blood or adoption who is reasonably available or "an adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient".
- A POLST does not replace an Advance Directive (AD). An AD is important to designate a decision-maker (DPOA-HC) in the event the patient becomes incapacitated or documents additional treatment preferences. Always check for inconsistencies between End-of-Life documents and correct as appropriate.
- Completion of a POLST should follow a discussion of the patient's goals, values and how their treatment preferences will impact both their longevity and quality of life.
- Patients discharged home should place the POLST next to their bed or on their refrigerator where EMS is trained to look.

**POLST Review** - This POLST should be reviewed periodically, and if:

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

**Voiding POLST**

- If the patient has decisional capacity, only the patient may void a POLST.
- If the patient lacks decisional capacity, the patient's DPOA-HC, parent of minor or legal guardian may revoke a POLST. However, a surrogate may *only* revoke a POLST completed by the surrogate. (see Completing a POLST, first bullet, above).

For additional information refer to NRS 449A.500 – 581, 2017

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