Nevada Department of Health and Human Services

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In 2017, Senate Bill 136 was passed establishing the Nevada Advisory Council on Palliative Care and Quality of Life. In collaboration with the Division of Public and Behavioral Health (DPBH), the council works to ensure that comprehensive and accurate information and education about palliative care is available to health care providers, health care facilities and members of the public.

The Nevada Palliative Care and Quality of Life Advisory Council (PCQL) is here promoting awareness and education on advanced care planning, hospice care, and the importance of quality end-of-life care. We hope to bring together clinic colleagues and peers throughout the state to share best practices, while also offering guidance to enhance understanding of palliative care and quality of life.

PCQL is celebrating National Healthcare Decisions Day by hosting a Virtual Palliative Care Awareness and Education Day that is reaching over 200 medical professionals.

Attached are resources for your viewing and education:
POLST- Provider Order for Life-Sustaining Treatment
Statutory Form Power of Attorney-Financial Power of Attorney
Durable Power of Attorney for Healthcare Decisions- Medical Power of Attorney

For more information visit our website:

http://dpbh.nv.gov/palliativecare/

STATUTORY FORM POWER OF ATTORNEY

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE DECISIONS CONCERNING YOUR PROPERTY FOR YOU. YOUR AGENT WILL BE ABLE TO MAKE DECISIONS AND ACT WITH RESPECT TO YOUR PROPERTY (INCLUDING YOUR MONEY) WHETHER OR NOT YOU ARE ABLE TO ACT FOR YOURSELF.

2. THIS POWER OF ATTORNEY BECOMES EFFECTIVE IMMEDIATELY UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.

3. THIS POWER OF ATTORNEY DOES NOT AUTHORIZE THE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

4. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

5. YOU SHOULD SELECT SOMEONE YOU TRUST TO SERVE AS YOUR AGENT. UNLESS YOU SPECIFY OTHERWISE, GENERALLY THE AGENT'S AUTHORITY WILL CONTINUE UNTIL YOU DIE OR REVOKE THE POWER OF ATTORNEY OR THE AGENT RESIGNS OR IS UNABLE TO ACT FOR YOU.

6. YOUR AGENT IS ENTITLED TO REASONABLE COMPENSATION UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.

7. THIS FORM PROVIDES FOR DESIGNATION OF ONE AGENT. IF YOU WISH TO NAME MORE THAN ONE AGENT YOU MAY NAME A CO-AGENT IN THE SPECIAL INSTRUCTIONS. CO-AGENTS ARE NOT REQUIRED TO ACT TOGETHER UNLESS YOU INCLUDE THAT REQUIREMENT IN THE SPECIAL INSTRUCTIONS.

8. IF YOUR AGENT IS UNABLE OR UNWILLING TO ACT FOR YOU, YOUR POWER OF ATTORNEY WILL END UNLESS YOU HAVE NAMED A SUCCESSOR AGENT. YOU MAY ALSO NAME A SECOND SUCCESSOR AGENT.

9. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT.

10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY.

11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF AGENT.

I, (*insert your name*) _____ do hereby designate and appoint:

Name: _____

Address: _____

Telephone Number: _____

as my agent to make decisions for me and in my name, place and stead and for my use and benefit and to exercise the powers as authorized in this document.

2. DESIGNATION OF ALTERNATE AGENT.

(*You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same decisions as the agent designated above in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.*)

If my agent is unable or unwilling to act for me, then I designate the following person(s) to serve as my agent as authorized in this document, such person(s) to serve in the order listed below:

A. First Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

3. OTHER POWERS OF ATTORNEY.

This Power of Attorney is intended to, and does, revoke any prior Power of Attorney for financial matters I have previously executed.

4. NOMINATION OF GUARDIAN.

If, after execution of this Power of Attorney, proceedings seeking an adjudication of incapacity are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

5. GRANT OF GENERAL AUTHORITY.

I grant my agent and any successor agent(s) general authority to act for me with respect to the following subjects:

(*INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.*)

[_____] Real Property

[_____] Tangible Personal Property

[_____] Stocks and Bonds

[_____] Commodities and Options

[_____] Banks and Other Financial Institutions

[_____] Safe Deposit Boxes

[_____] Operation of Entity or Business

[_____] Insurance and Annuities

[_____] Estates, Trusts and Other Beneficial Interests

[_____] Legal Affairs, Claims and Litigation

[_____] Personal Maintenance

[_____] Benefits from Governmental Programs or Civil or Military Service

[_____] Retirement Plans

[_____] Taxes

[_____] All Preceding Subjects

6. GRANT OF SPECIFIC AUTHORITY.

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(*CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.*)

[_____] Create, amend, revoke or terminate an inter vivos, family, living, irrevocable or revocable trust

[_____] Make a gift, subject to the limitations of NRS and any special instructions in this Power of Attorney

[_____] Create or change rights of survivorship

[_____] Create or change a beneficiary designation

[_____] Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

[_____] Exercise fiduciary powers that the principal has authority to delegate

[_____] Disclaim or refuse an interest in property, including a power of appointment

[_____] Consent to placement in an assisted living facility as defined in NRS 422.3962

[_____] Consent to placement in a facility for skilled nursing as defined in NRS 449.0039

[_____] Consent to placement in a secured residential long-term care facility as defined in NRS 159.0255

7. EXPRESSION OF INTENT CONCERNING LIVING ARRANGEMENTS.

[_____] It is my intention to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

[_____] It is my intention to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

[_____] I desire for my agent to take the following actions relating to my care:

_____

_____

_____

8. LIMITATION ON AGENT'S AUTHORITY.

An agent that is not my spouse MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

9. SPECIAL INSTRUCTIONS OR OTHER OR ADDITIONAL AUTHORITY GRANTED TO AGENT:

_____

_____

_____

_____

_____

10. AUTHORITY OF PRINCIPAL.

Except as otherwise expressly provided in this Power of Attorney, the authority of a principal to act on his or her own behalf continues after executing this Power of Attorney and any decision or instruction communicated by the principal supersedes any inconsistent decision or instruction communicated by an agent appointed pursuant to this Power of Attorney.

11. DURABILITY AND EFFECTIVE DATE. (*INITIAL the clause(s) that applies.*)

[_____] DURABLE. This Power of Attorney shall not be affected by my subsequent disability or incapacity.

[_____] SPRINGING POWER. It is my intention and direction that my designated agent, and any person or entity that my designated agent may transact business with on my behalf, may rely on a written medical opinion issued by a licensed medical doctor stating that I am disabled or incapacitated, and incapable of managing my affairs, and that said medical opinion shall establish whether or not I am under a disability for the purpose of establishing the authority of my designated agent to act in accordance with this Power of Attorney.

[_____] I wish to have this Power of Attorney become effective on the following date:.....

[_____] I wish to have this Power of Attorney end on the following date:.....

12. THIRD PARTY PROTECTION.

Third parties may rely upon the validity of this Power of Attorney or a copy and the representations of my agent as to all matters relating to any power granted to my agent, and no person or agency who relies upon the representation of my agent, or the authority granted by my agent, shall incur any liability to me or my estate as a result of permitting my agent to exercise any power unless a third party knows or has reason to know this Power of Attorney has terminated or is invalid.

13. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information, by any government agency, business, creditor or third party who may have information pertaining to my assets or income, to my agent named herein.

14. SIGNATURE AND ACKNOWLEDGMENT. YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I sign my name to this Power of Attorney on (*date*) _____ at

(*city*) _____, (*state*) _____

(*Signature*) _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(*You may use acknowledgment before a notary public instead of the statement of witnesses.*)

State of Nevada }
}ss.
County of _____ }

On this _____ day of _____, in the year _____, before me, (*here insert name of notary public*) _____ personally appeared (*here insert name of principal*) _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(*Signature of Notary Public*)

IMPORTANT INFORMATION FOR AGENT

1. Agent's Duties. When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the Power of Attorney is terminated or revoked. You must:

   (a) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

   (b) Act in good faith;

   (c) Do nothing beyond the authority granted in this Power of Attorney; and
   (d) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

   (Principal's Name) by (Your Signature) as Agent

2. Unless the Special Instructions in this Power of Attorney state otherwise, you must also:

   (a) Act loyally for the principal's benefit;

   (b) Avoid conflicts that would impair your ability to act in the principal's best interest;

   (c) Act with care, competence, and diligence;

   (d) Keep a record of all receipts, disbursements and transactions made on behalf of the principal;

   (e) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and

   (f) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

3. Termination of Agent's Authority. You must stop acting on behalf of the principal if you learn of any event that terminates this Power of Attorney or your authority under this Power of Attorney. Events that terminate a Power of Attorney or your authority to act under a Power of Attorney include:

   (a) Death of the principal;

   (b) The principal's revocation of the Power of Attorney or your authority;

(c) The occurrence of a termination event stated in the Power of Attorney;

(d) The purpose of the Power of Attorney is fully accomplished; or

(e) If you are married to the principal, your marriage is dissolved.

4. Liability of Agent. The meaning of the authority granted to you is defined in NRS 162A.200 to 162A.660, inclusive. If you violate NRS 162A.200 to 162A.660, inclusive, or act outside the authority granted in this Power of Attorney, you may be liable for any damages caused by your violation.

5. If there is anything about this document or your duties that you do not understand, you should seek legal advice.

The following meets the requirements of a "Durable Power of Attorney for Health Care Decisions" provided for under NRS 162A:

NEVADA DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Healthcare. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Agent the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.

3. Except as you otherwise specify in this document, the Power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the medical physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Healthcare.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name: _____

Address: _____

Telephone Number: _____

as my Agent to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your Agent to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This Power of Attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the agent named above full power, and authority: to make health care decisions for me before, or after my death, including consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on your agent's authority, you should list them in the space below. If you do not want any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for healthcare, the authority of my agent is subject to the following special provisions and limitations:

_____

_____

_____

5. DURATION

I understand that this Power of Attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date: _____

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. _____

2. If I am in a coma which my doctors have reasonable concluded is irreversible, I desire that life sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed). _____

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed). _____

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld _____

5. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My agent is to consider relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. _____

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires: _____

_____

_____

_____

7. DESIGNATION OF ALTERNATE AGENT

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your agent.. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my agent is unable to make health care decision for me, then I designate the following persons to serve as my agent to
make heath care decisions for me as authorized in this document, such person to serve in the order listed below:

A. First Alternative Agent

Name: _____

Address: _____

_____

Telephone Number: _____

B. Second Alternative Agent

Name: _____

Address: _____

_____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Healthcare:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)
I sign my name to this Durable Power of Attorney for Healthcare on: _____
(Date)

at _____, _____
(City) (State)

_____
(Signature)

9. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

10. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to authorize and allow full release of information by any government agency, medical provider, business, creditor, or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

13. (THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a notary public instead of statement of witnesses.)

State of Nevada)
: ss:
County of _____)

On this _____ day of _____, in the year _____,

before me, _____ (here insert name of

notary public) personally appeared _____ (here

insert name of principal) personally known to me (or proved to me on the basis of satisfactory

evidence) to be the person whose name is subscribed to this instrument, and acknowledged that

he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to

this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL _____
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a healthcare facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of health care facility.

Witness #1:

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

Witness #2:

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing by operation of law.

Witness #1:

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

Witness #2:

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

COPIES: You should retain an executed copy of this document and give one to your agent. The Power of Attorney should be available so a copy may be given to your providers of health care.

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 a 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