## PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORM

**DEPARTMENT OF HEALTH SERVICES**  
**COUNTY OF LOS ANGELES**

**SUBJECT:** PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORM

**REFERENCE NO. 815.2**

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

### Cardiopulmonary Resuscitation (CPR):

- If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)

- Do Not Attempt Resuscitation/DNR (Allow Natural Death)

### Medical Interventions:

- If patient is found with a pulse and/or is breathing.

  - Full Treatment – primary goal of prolonging life by all medically effective means.
    - Trial Period of Full Treatment.
  
  - Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
    - In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
    - Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

  - 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.

### Artificially Administered Nutrition:

- Offer food by mouth if feasible and desired.

### Information and Signatures:

- Discussed with:  
  - Patient (Patient Has Capacity)
  - Legally Recognized Decisionmaker

  - Advance Directive dated, available and reviewed
  - Health Care Agent if named in Advance Directive: Name:
  - Phone:

- Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
  - My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s medical condition and preferences.

  - Print Physician/NP/PA Name:  
  - Physician/NP/PA Phone #:  
  - Physician/PA License #, NP Cert. #:  

- Signature of Patient or Legally Recognized Decisionmaker
  - I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

  - Print Name:  
  - Relationship: (write self if patient)

  - Signature: (required)  
  - Date:

  - Mailing Address (street/city/state/zip):  
  - Phone Number:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

**EFFECTIVE:** 01-30-09  
**REVISED:** 04-01-19  
**SUPERSEDES:** 09-01-15