Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

This is a Physician Order guided by the patient's medical condition and based upon personal preferences verbalized to the Physician or expressed in an Advance Directive.

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Last four digits of SSN:_____ Date of Birth _____ Gender: Male ☐ Female ☐

A **CODE STATUS** Check all that apply	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** ☐ Resuscitation Orders are to remain in effect during any surgical or invasive procedure. When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: Includes **Comfort Measures** and medical treatment, IV fluids, and cardiac monitor as indicated. Does not include intubation or mechanical ventilation. *Avoid intensive care*. *Transfer to hospital if indicated.* ☐ **Additional Treatment**: Includes **Limited Additional Interventions**, lab tests, blood products. *Transfer to hospital if indicated*. ☐ **Full Treatment**: Includes **Additional Treatment** and intubation, mechanical ventilation, and cardioversion as indicated. *Includes intensive care*. *Transfer to hospital if indicated.* ☐ Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. ☐ Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMIINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. ☐ Additional Orders: ☐ No IV fluids. ☐ Defined trial period of IV fluids. ☐ Long-term IV fluids.
E Check All That Apply	**REASON FOR ORDERS AND SIGNATURES** To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences as indicated by: ☐ My discussion with the Patient ☐ My discussion with the Patient's Authorized Representative ☐ My review of the Patient's Advance Directive ☐ Verbal consent was given for an "allow natural death" order

Physician's Printed Name License No. State	Physician's Signature	Date Phone	
Patient's Printed Name	Patient's Signature	Date	Phone
Patient Authorized Representative's Printed Name (if patient lacks decision making capacity)	Representative's Signature (if patient lacks decision making capacity)	Date	Phone

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- This form should be completed by a health care professional based on the patient's medical condition, and on the patient's wishes, as expressed to the physician by the patient while in a competent condition, or in the patient's advance directive, or by a representative of the patient acting with legal authority.
- This form should be signed by a physician, **and** also by the patient **or,** if the patient lacks decision making capacity, a representative acting with legal authority on behalf of the patient.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are valid.
- **Any incomplete section of POLST implies full treatment for that section.**
- Do not use a defibrillator (including AEDs) on a person who has chosen "allow natural death."
- Always offer fluids and nutrition by mouth if medically feasible.
- Transfer the patient to a setting better able to provide comfort when it cannot be achieved in the current care setting (*e.g.*, treatment of a hip fracture).
- A patient with capacity, or the authorized representative of a patient without capacity, may request alternative treatment.
- **Treatment of dehydration is a measure which prolongs life. A patient who desires IV fluids should indicate "Limited Additional Intervention" or higher level of care.**

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient's health status, or (iv) the patient's treatment preferences change. **If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A though D, write "VOID" in large letters with date and time, and sign by the line.** After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			☐ No Change ☐ Form Voided, new form completed ☐ Form Voided, no new form	
			☐ No Change ☐ Form Voided New Form Completed ☐ Form Voided, no new form	

This form was prepared by the Georgia Department of Public Health pursuant to Official Code of Georgia Section 29-4-18(l). O.C.G.A. § 29-4-18(k)(3) provides: *"Any person who acts in good faith in accordance with a Physician Order for Life-sustaining treatment developed pursuant to subsection (l) of this Code section shall have all of the immunity granted pursuant to Code Section 31-32-10."* **O.C.G.A. § 31-32-10 provides, in pertinent part:** *"Each health care provider, health care facility, and any other person who acts in good faith reliance … shall be protected and released to the same extent as though such person had interacted directly with the [patient] as a fully competent person."*