Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

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

Date of Birth _____ **Gender**: Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** *** Signature of a concurring physician is needed for this section to be valid **if** this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **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**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit 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 ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible**
	☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders:
	☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):

☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

GUIDANCE FOR COMPLETING THE POLST FORM

1. Completion of a POLST form is always voluntary**.**
2. Any section of a POLST form which is not completed implies full treatment for interventions discussed in that section.
3. A POLST form may be executed/created:
   a. when a patient has a serious illness or condition and the attending physician's reasoned judgment is that the patient will die within the next 365 days OR
   b. at any time if a person has been diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking, and behavior.
4. **If the patient has decision making capacity**, that patient chooses whether to complete and sign the POLST form with his or her physician. An authorized person may NOT sign the POLST form for a patient who has decision making capacity.
5. **If the patient lacks decision making capacity**, the POLST form may be signed by an "authorized person", which includes, in the following order of priority:
   a. the agent named on the patient's durable power of attorney for health care or a health care agent named on the patient's advance directive for health care
   b. a spouse
   c. a court-appointed guardian
   d. son or daughter (age 18 or older)
   e. parent
   f. brother or sister (age 18 or older)
6. If an authorized person completes and signs the POLST form, treatment choices should be based in good faith on what the patient would have wanted if the patient understood his or her current circumstances.

ADDITIONAL GUIDANCE FOR HEALTH CARE PROFESSIONALS

I. When a POLST form is signed by the Patient and Attending Physician**,** all orders may be implemented without restriction.

II. When a POLST form is signed by the patient's Health Care Agent and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). However, a concurring physician signature is NOT required per Georgia Code Section 31-92-4(c).
   ii. Orders in Sections B, C and D may be implemented without restriction.

III. When a POLST form is signed by an Authorized Person (other than the patient's Health Care Agent) and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). A concurring physician signature is REQUIRED per Georgia Code Section 31-39-4(c).
   ii. Orders in B, C, or D may be implemented when patient is:
      a. in a terminal condition OR
      b. state of permanent unconsciousness OR
      c. diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking and behavior.

IV. The status of resuscitation orders during surgery or other invasive procedures should be reviewed by the physician with the patient or patient's "authorized person" (as defined above).

V. Copies of the original POLST form are valid.

VI. The POLST form shall remain effective unless revoked by the attending physician upon the consent of the patient or the patient's authorized person.

VII. An attending physician who issues an order using the POLST form and who transfers the patient to another physician shall inform the receiving physician and the health care facility, if applicable, of the order**.**

VIII. A health care facility may impose additional administrative or procedural requirements regarding a patient's end of life care decisions, including the use of a separate order form. If the patient is in a health care facility, the attending physician should check with the facility to ensure these orders are valid.

***** Georgia Code Section 31-92-2(4) defines a "candidate for non-resuscitation" to mean a patient who, based on a reasonable degree of medical certainty:

(A) has a medical condition which can reasonably be expected to result in the imminent death of the patient;
(B) is in a non-cognitive state with no reasonable possibility of regaining cognitive functions; or
(C) is a person for whom CPR would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely experience repeated need for CPR over a short period of time or that such resuscitation would be otherwise medically futile.

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**	