**Physician Orders for Life-Sustaining Treatment (POLST)-Florida**

Follow these orders until orders are reviewed. These medical orders are based on the patient’s current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

If the patient has decision-making capacity, the patient’s presently expressed wishes should guide his or her treatment.

### Patient Information

- **Patient Last Name**
- **Patient First Name**
- **Middle Int.**
- **Date of Birth: (mm/dd/yyyy)**
- **Gender**
  - [ ] M
  - [ ] F
- **Last 4 SSN:**

### A. Cardiopulmonary Resuscitation (CPR)

- [ ] Attempt Resuscitation/CPR
- [ ] Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in B and C.

### B. Medical Interventions

- [ ] Full Treatment – goal is to prolong life by all medically effective means.
  - **Care Plan:** Full treatment including life support measures in the intensive care unit.
- [ ] Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures
  - **Care Plan:** Provide basic medical treatments.
- [ ] Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering
  - **Care Plan:** Maximize comfort through symptom management.

Additional Orders:

**ARTIFICIALLY ADMINISTERED NUTRITION**

- [ ] Long-term artificial nutrition by tube.
  - **Additional Instructions:**
- [ ] Defined trial period of artificial nutrition by tube.
  - **Additional Instructions:**
- [ ] No artificial nutrition by tube.
  - **Additional Instructions:**

### D. Hospice or Palliative Care

- [ ] Patient/Resident Currently enrolled in Hospice Care
  - **Contact:**
- [ ] Patient/Resident Currently enrolled in Palliative Care
  - **Contact:**
- [ ] Not indicated or refused
  - **Contact:**

### SIGNATURES

- **Print Physician Name**
- **Physician Signature (mandatory)**
- **Print Patient/Resident or Surrogate/Proxy Name**
- **Patient or Surrogate Signature (mandatory)**

### Additional Information

**Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST are legal and valid.**
**DOCUMENTATION OF DISCUSSION:**

- [ ] Patient (Patient has capacity)
- [ ] Health Care Representative or surrogate
- [ ] Parent of minor
- [ ] Court-Appointed Guardian
- [ ] Other (proxy)

**Other Contact Information**

<table>
<thead>
<tr>
<th>Name of Guardian, Surrogate or other Contact Person</th>
<th>Relationship</th>
<th>Phone Number/Address</th>
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<thead>
<tr>
<th>Name of Health Care Professional Preparing Form</th>
<th>Preparer Title</th>
<th>Phone Number</th>
<th>Date Prepared</th>
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</table>

**Directions for Health Care Professionals**

**Completing POLST**

- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

**Using POLST**

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen “Do Not Attempt Resuscitation.”
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with “comfort measures only,” should be transferred to a setting able to provide comfort, such as a hospice unit.
- A person who chooses either “comfort measures only” or “limited additional interventions” should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

**Reviewing POLST**

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The person is transferred from one care setting or care level to another, or
2. There is a substantial change in the person’s health status, or
3. The person’s treatment preferences change.

To void this form, draw line through sections A through D on page 1 and write “VOID” in large letters.

**Review of this POLST Form**

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<thead>
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<th>Review Date</th>
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<th>Location of Review</th>
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<td>New form completed</td>
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</tbody>
</table>

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

REVISED FORM (JULY 10, 2015)