

## Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First Name/ Middle Initial

Date of Birth

**A** **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Check  Attempt Resuscitation/CPR     Do Not Attempt Resuscitation/DNR (Allow Natural Death)  
 One When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

**B** **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Check  **Comfort Measures Only** Use medication by any route, positioning, wound care and other  
 One 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. Transfer if comfort needs cannot be met in current location.*

**Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer to hospital if indicated. Avoid intensive care.*

**Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

Additional Orders: \_\_\_\_\_

**C** **ANTIBIOTICS**  
 Check  No antibiotics. Use other measures to relieve symptoms.  
 One  Determine use or limitation of antibiotics when infection occurs.  
 Use antibiotics if life can be prolonged.

Additional Orders: \_\_\_\_\_

**D** **ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food by mouth if feasible.  
 Check  No artificial nutrition by tube.  
 One  Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.

Additional Orders: \_\_\_\_\_

### REASON FOR ORDERS AND SIGNATURES

**E** Discussed with:  Patient    My signature below indicates these orders are consistent with  
 Parent of Minor    the person's preferences, if known. See medical record for  
 Health Care Representative    further documentation.  
 Court-Appointed Guardian  
 Other: \_\_\_\_\_

Print Physician/NP/PA Name and Phone Number

(    )

Physician/NP /PA Signature (mandatory)

Date

For forms for use in Pennsylvania, send email to: [aging@upmc.edu](mailto:aging@upmc.edu), or call the University of Pittsburgh Institute on Aging at 1-866-430-8742