



**Using the Montana POLST Form  
Guidance for Healthcare Professionals**

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## Using the Montana POLST Form Guidance for Healthcare Professionals

These guidelines were created to assist Montana health care professionals in completing the POLST form. This draft is referenced and amended from nationally endorsed state POLST programs, including West Virginia, Wisconsin, Oregon, Washington and New York. The purpose of the guidelines will also help Montana's POLST process meet national POLST endorsement criteria.

Additionally, the guidelines are based on the recommendations of the Montana POLST Coalition, which is made up of providers, DPHHS EMS representatives, DOJ's End-of-Life Registry and the BOME. It is our hope that the addition of guidelines for usage will streamline utilization of the 2011 updated POLST Form.

### INTRODUCTION

The Montana "Provider Orders for Life Sustaining Treatment" (POLST) form is a document designed to help health care professionals know and honor the treatment wishes of their patients. The POLST form helps physicians, nurses, long-term care facilities, hospices, home health agencies, emergency medical services and hospitals:

- promote patient autonomy by documenting treatment preferences and converting them into physician's orders;
- clarify treatment intentions and minimize confusion regarding patients' treatment preferences;
- facilitate appropriate treatment by emergency medical services personnel; and
- enhance the HIPAA-compliant transfer of patients' records between health care professionals and health care settings.

The POLST form:

- is intended to enhance the quality of a person's care and to complement the advance care planning process.
- is a short summary of treatment preferences and a clear physician's order for care in an emergency situation.
- is not intended to replace a living will or medical power of attorney form.
- puts the advance directive into action by translating the patient's treatment wishes into a medical order, centralizing information, facilitating record-keeping and ensuring transfer of appropriate information among health care professionals and across settings.

Use of the POLST form is voluntary and conforms to the Montana Rights of the Terminally Ill Act, **Montana Code Annotated, 50-9-101**. It may not be legally recognized in bordering states. However, facilities in bordering states may be willing to record the physician's orders in the medical chart and work with MT facilities to make sure they honor a patient's wishes.



## HOW TO IMPLEMENT THE POLST FORM

The POLST form should be completed after discussion with the patient, incapacitated patient's medical power of attorney representative or surrogate decision-maker regarding treatment preferences. The POLST conversation may be facilitated by health care professionals other than a provider, including nurses and social workers who have knowledge of end-of-life care issues and have been trained to conduct these discussions.

The Respecting Choices® POLST Paradigm Program ACP Facilitator Course is an example of a curriculum that would certify (or validate) the skill set of health care professionals in discussing these issues and choices with patients and families. This same professional staff may also assist the patient with completion of the POLST form; however, **the form must be signed by a medical provider** licensed in Montana who has examined the patient. The medical provider may be either a physician, physician assistant or advanced practice registered nurse. The provider who completes the form can be the patient's attending provider or another provider involved in the patient's care; s/he assumes full responsibility for the orders.

- **Who Should Have a POLST Form?**

The POLST form should be completed for individuals with a life-limiting illness who may need life-sustaining treatment in the future to survive. The "surprise" question ("Would you be surprised if this patient died in the next year?") is helpful to identify patients who could benefit from the form.

The POLST form is also highly recommended for hospitalized patients being discharged to a nursing home, or to home with home health or hospice care. Other nursing home residents can potentially be identified during quarterly care planning.

- **Who Should NOT Have a POLST Form**

A POLST form should not be completed in the following circumstances:

1. The patient indicates that he/she wants to be a full code and the patient is not willing to initial the box in **Section F** allowing their medical power of attorney representative/health care agent/surrogate to change the form should the patient's medical condition change.
2. The patient indicated he/she wants full treatment and is not willing to initial the box in **Section F** allowing his/her medical power of attorney representative/health care agent/surrogate to change the form should the patient's medical condition change.
3. The patient requests contradictory orders: for example, the patient wants CPR in **Section A** but wants only limited additional interventions in **Section B**. The performance of CPR requires full treatment. If the patient does not want full treatment including intubation and mechanical ventilation in an ICU, then the patient should not receive CPR.



- **Pediatric Considerations**

Since arrest in most children is primarily respiratory, a child is more likely to be found with a pulse than an adult. If a child has any respiratory effort or pulse, the child should be treated as directed under **Section B**.

### **Identification of Existing POLST form**

- **Previous versions of POLST forms remain valid until replaced by new version.**
- For those persons in institutional settings the form by law must accompany the person upon transfer from one setting to another.
- In the patient's home, it is recommended that the form be kept on the outside of the kitchen refrigerator with a magnet.
  - For those at home, the form by law must accompany the patient to a health care setting.
- A copy of the form on **white paper** may be sent rather than the original. For photocopying instructions please refer to the section below.

### **Photocopying the POLST Form** (*HIPAA permits disclosure of POLST information to other health care professionals across treatment settings*)

A photocopy of the POLST form (on white paper) should be made to accompany the patient when he/she is transferred from one health care setting to another (e.g. being admitted from a nursing home to a hospital).

The reason to send a copy and retain the original is to prevent the original from being lost in a patient's transfer from one health care setting to another.

### **SECTION BY SECTION REVIEW OF THE POLST FORM**

The POLST form is a double-sided **terra green** form. One side of the form contains the provider orders (**Sections A-E**). The other side of the form includes an area for documentation of other types of advance directives (**Section F**) and the signatures of the patient (or the designated health care agent) and the professional who assisted with the form completion. This side also has a section for periodic review of the POLST form (**Section G**). See page 9.

#### **I. Provider Orders (Sections A-E):**

The four different medical treatments or services include: A) Cardiopulmonary Resuscitation, B) Medical Interventions, C) Antibiotics, and D) Artificially Administered Nutrition. Section B includes who discussed the orders with the health care provider, the basis for the orders (patient's preferences or best interest), and section for the provider's mandatory signature and contact information.



**A- Cardiopulmonary Resuscitation usage guideline**

<p><b>Section A</b> Select only one box</p>	<p><b>Treatment Options:</b> If patient does not have a pulse and is not breathing:</p> <p><input type="checkbox"/> <b>Resuscitate (CPR)</b>                      <input type="checkbox"/> <b>Do Not Resuscitate (DNR/No CPR)</b> (Allow Natural Death)</p> <p>If patient is not in cardiopulmonary arrest, follow orders found in sections <b>B</b> and <b>C</b></p>
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***These orders apply only to the circumstances in which the person has no pulse and is not breathing.*** If a patient is in respiratory distress but is still breathing or has low blood pressure with an irregular pulse, a first responder should refer to sections B, C and D for corresponding orders.

- **Resuscitate** is used if the person wants cardiopulmonary resuscitation (CPR). Full CPR measures should be carried out and 9-1-1 should be called in an emergency situation.
- **Do Not Resuscitate (DNR/no CPR)** is used if a person has indicated that s/he does not want CPR in the event of no pulse and no breathing. The person should understand that comfort measures will always be provided and that CPR will not be attempted.

**B- Medical Interventions usage guideline**

<p><b>Section B</b> Select only one box</p>	<p><b>Treatment Options:</b> If patient has a pulse and/or is breathing:</p> <p><input type="checkbox"/> <b>Comfort Measures:</b> Treat patient with dignity and respect. Keep patient clean, warm and dry. Reasonable measures are to be made to offer food and fluids by mouth. Use medication, positioning, wound care and other measures to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>DO NOT transfer to hospital for life-sustaining treatment. Transfer ONLY if comfort needs cannot be met in current location.</b></p> <p><input type="checkbox"/> <b>Limited Additional Interventions:</b> In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. <b>Transfer to hospital if indicated. <u>Avoid Intensive Care.</u></b></p> <p><input type="checkbox"/> <b>Full Treatment:</b> In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. <b>Transfer to hospital if indicated. <u>Include Intensive Care.</u></b></p> <p><b>Other Instructions:</b> _____</p> <p>_____</p>
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***These orders apply only to emergency medical circumstances for a person who has a pulse and/or is breathing.*** This section provides orders for situations that are not covered in Section A. These orders were developed in accordance with EMS protocol. Health care professionals should first administer the level of emergency medical services ordered and then contact the physician.

- **Comfort Measures** indicates a desire for only those interventions that enhance comfort. Care to promote comfort should always be provided regardless of ordered level of treatment. 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 a hospital for life-sustaining treatment.** Only transfer to a hospital if comfort needs cannot be met in current location.



- **Limited Additional Interventions**, in addition to the comfort measures noted above, include IV fluids and cardiac monitoring as indicated. **Do not use intubation, advanced airway interventions or mechanical ventilation.** Transfer to hospital may be indicated, but use of intensive care is avoided.
- **Full Treatment** includes all care noted above with no limitation of medically indicated treatment. All support measures needed to maintain and extend life are utilized. Use intubation, advanced airway interventions, mechanical ventilation, and electrical cardioversion as indicated. Transfer to hospital and use intensive care as medically indicated.

### C- Antibiotics usage guideline

<b>Section C</b> Select only one box	<b>Antibiotics:</b> <input type="checkbox"/> No antibiotics except if needed for comfort (i.e. urinary tract infection) <input type="checkbox"/> No invasive ( <b>IM/IV</b> ) antibiotics <input type="checkbox"/> Aggressive treatment	<b>Other instructions:</b> _____
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- **No antibiotics** indicates a preference for nothing except what might be needed to alleviate symptoms of pain or discomfort.
- **No invasive (IM/IV) antibiotics** would mean treatment with only oral antibiotics.
- **Aggressive treatment** is for those who desire antibiotics with the intent to prolong life.

### D- Medically Administered Fluids and Nutrition

<b>Section D</b> Select only one box	<b>Medically Administered Nutrition:</b> <input type="checkbox"/> No Feeding tube <input type="checkbox"/> Feeding tube for defined trial period <input type="checkbox"/> Feeding tube long-term	<b>Other Instructions:</b> _____
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These orders pertain to a person who cannot take fluids and food by mouth.

- **No Feeding tube** indicates a patient or their medical power of attorney representative/ health care agent/surrogate made a choice of no tube feeding.
- **Feeding tube for a defined trial period** means the patient or medical surrogate has decided on a trial of artificial nutrition by tube to allow time to determine the course of an illness or allow the person an opportunity to clarify goals of care.
- **Feeding tube long term** would be for those who desire consistent hydration and nutrition.
- **Other instructions** would be helpful to identify patient's related values and beliefs about living well.



# Montana Board of Medical Examiners

## POLST

### Provider Orders for Life-Sustaining Treatment

#### E- Provider's Signature

<b>Section E</b>	<p>Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Healthcare Agent/Surrogate <input type="checkbox"/> Court appointed Guardian</p> <p><input type="checkbox"/> Other _____</p> <p>Name of Agent/Surrogate/Guardian/Other: _____</p> <p>Phone #: _____</p> <p>The basis for these orders is: <input type="checkbox"/> Patient's preference <input type="checkbox"/> Patient's best interest</p> <p><input type="checkbox"/> Other _____</p>
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<u>Signature of Physician/PA/NP (mandatory)</u>	<u>Physician/PA/NP Name (type or print)</u>	<u>Time and Date</u>
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**FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED**  
*Use of original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are valid*

Upon completion of the orders, the health care professional checks the box indicating with whom the orders were discussed. At the bottom of the orders, *the provider must sign the form*. Without this signature, the orders are **NOT** valid. The signer must also print his/her name and the time and date the orders were written. The bottom of the form contains a written reminder that the form should accompany the patient/resident when transferred or discharged.



# Montana Board of Medical Examiners

## POLST

### Provider Orders for Life-Sustaining Treatment

## II. Back side (Sections F-G)

### F- Patient Preferences as a Guide for the POLST Form

<b>Section F</b>	<b>Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POLST Form</b>							
	<p>I have given significant thought to life-sustaining treatment. I have expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following have further information regarding my preferences.</p>							
	Advance Directive	<input type="checkbox"/> NO	<input type="checkbox"/> YES					
	Court-appointed Guardian	<input type="checkbox"/> NO	<input type="checkbox"/> YES					
	<p><b>Review and discuss these orders if there is substantial change in my health status, such as:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Advanced progressive illness</td> <td style="width: 33%;">Close to death</td> <td style="width: 33%;">Extraordinary suffering</td> </tr> <tr> <td>Improved condition</td> <td>Permanent unconsciousness</td> <td></td> </tr> </table>			Advanced progressive illness	Close to death	Extraordinary suffering	Improved condition	Permanent unconsciousness
Advanced progressive illness	Close to death	Extraordinary suffering						
Improved condition	Permanent unconsciousness							
<b>Signature of Patient/Resident, Parent of minor or Guardian/Healthcare Agent (optional)</b>								
<b>Signature of Person preparing form</b>	<b>Preparer Name (please print)</b>	<b>Date form prepared</b>						

- **Advance Directive** may be a living will, medical power of attorney for health care, an organ and tissue document of a gift, court-appointed guardian or health care agent/surrogate selection form.
- **Court-appointed Guardian** indicates the presence of someone authorized to make medical decisions when the patient loses that capacity.

The existence of a medical power of attorney for health care/agent/surrogate/guardian grants leeway to allow decisions to be made by the patient's named decision maker that are more appropriate to the present circumstances as opposed to the circumstances at the time the patient completed the POLST form.

**A form lacking the patient or legal decision-maker signature and date/signature of the person preparing the form is invalid.**



# Montana Board of Medical Examiners

## POLST

### Provider Orders for Life-Sustaining Treatment

#### G- Review of the POLST Form

Section G	Review of this POLST Form			
	Date	Reviewer	Location of Review	Outcome of Review
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form

This section provides for up to four reviews of the POLST when the patient has changed health care settings or after changes in the patient's status. Some long-term care facilities may also do a periodic review of the POLST form to ensure the orders listed on the form are in agreement with the patient's current wishes according to his/her current health care status. Nursing homes who choose to review the form quarterly, even when the patient has not been hospitalized, may want to document the review in the resident's care conference notes or social services notes so that Section G is not completely filled in with "**No change**" outcomes requiring a new form to be completed.

- **No change** is checked after the POLST form has been reviewed and there were no changes made, whether after a change of setting or periodic review of the form.
- **Form voided, new one completed** is checked if, for any reason, the POLST form was voided after review and a new form was completed.
  - After checking this box, the word "VOID" should be written in large letters across both the front and back of the POLST form.
  - The date the form was voided should be written under the word "VOID", and a new form should be completed.
  - The old voided form should be kept in the patient's medical records, whether in the current file or in an archived file, depending on how your facility maintains patients' records.



- The newly completed POLST form should then be kept in the front of the patient's current medical records file.
- **Form voided, no new form** is checked if the POLST form was voided after review and the decision was made that a new POLST form was not to be completed.
  - After checking this box, the word "VOID" should be written in large letters across both the front and back of the POLST form
  - The date the form was voided should be written under the word "VOID."
  - The old voided form should be kept in the patient's medical records, whether in a current file or in an archived file, depending on how the facility maintains patient records.

POLST forms, envelopes and bracelets may be ordered from:

**Department of Public Health and Human Services**  
**EMS & Trauma System Section**  
**(406) 444-3895**  
[emsinfo@mt.gov](mailto:emsinfo@mt.gov)

Source: POLST Guideline Usages from West Virginia and Wisconsin POLST. Materials per links from National POLST Organization website (<http://www.ohsu.edu/polst/index.htm>) updated 1/18/2011.

The guideline for usage was originally developed and endorsed by the Missoula/Regional Community Coalition for MT POLST Paradigm Process Improvement in collaboration with representatives from the following hospitals, nursing homes, and hospices:

St. Patrick Hospital and Health Sciences Center  
St. Joseph Medical Center  
Community Medical Center  
Partners in Home Care Hospice  
Hospice of Missoula  
Home Health of Montana  
Village Health Care Center  
Riverside Health Care Center  
Hillside Healthcare Center  
Valley View Estates, Hamilton, MT

<b>Montana Provider Orders For Life-Sustaining Treatment (POLST)</b>		
<p style="text-align: center; font-size: small;">THIS FORM MUST BE SIGNED BY A <b>PHYSICIAN, PA or APRN</b> IN SECTION E TO BE VALID</p> <p style="text-align: center;"><b>If any section is NOT COMPLETE: Provide the most treatment included in that section</b></p> <p style="text-align: center; font-size: small;"><b>EMS:</b> If questions/concerns, contact Medical Control.</p>	<p>Patient's Last Name: _____</p> <hr/> <p>Patient's First Name: _____</p> <hr/> <p>Date of Birth: _____</p> <hr/> <p>Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p><b>Section A</b> Select only one box</p>	<p><b>Treatment Options:</b> If patient does not have a pulse and is not breathing:</p> <p><input type="checkbox"/> <b>Resuscitate (CPR)</b>                      <input type="checkbox"/> <b>Do Not Resuscitate (DNR/No CPR)</b> (Allow Natural Death)</p> <p>If patient is not in cardiopulmonary arrest, follow orders found in sections <b>B</b> and <b>C</b></p>	
<p><b>Section B</b> Select only one box</p>	<p><b>Treatment Options:</b> If patient has a pulse and/or is breathing:</p> <p><input type="checkbox"/> <b>Comfort Measures:</b> Treat patient with dignity and respect. Keep patient clean, warm and dry. Reasonable measures are to be made to offer food and fluids by mouth. Use medication, positioning, wound care and other measures to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>DO NOT transfer to hospital for life-sustaining treatment. Transfer ONLY if comfort needs cannot be met in current location.</b></p> <p><input type="checkbox"/> <b>Limited Additional Interventions:</b> In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. <b>Transfer to hospital if indicated. Avoid Intensive Care.</b></p> <p><input type="checkbox"/> <b>Full Treatment:</b> In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. <b>Transfer to hospital if indicated. Include Intensive Care.</b></p> <p><b>Other Instructions:</b> _____</p>	
<p><b>Section C</b> Select only one box</p>	<p><b>Antibiotics:</b></p> <p><input type="checkbox"/> No antibiotics except if needed for comfort (i.e. urinary tract infection)</p> <p><input type="checkbox"/> No invasive (<b>IM/IV</b>) antibiotics</p> <p><input type="checkbox"/> Aggressive treatment                      <b>Other instructions:</b> _____</p>	
<p><b>Section D</b> Select only one box</p>	<p><b>Medically Administered Nutrition:</b></p> <p><input type="checkbox"/> No Feeding tube</p> <p><input type="checkbox"/> Feeding tube for defined trial period</p> <p><input type="checkbox"/> Feeding tube long-term                      <b>Other Instructions:</b> _____</p>	
<p><b>Section E</b></p>	<p><b>Discussed with:</b> <input type="checkbox"/> Patient/Resident    <input type="checkbox"/> Healthcare Agent/Surrogate    <input type="checkbox"/> Court appointed Guardian</p> <p style="padding-left: 40px;"><input type="checkbox"/> Other _____</p> <p><b>Name of Agent/Surrogate/Guardian/Other:</b> _____</p> <p><b>Phone #:</b> _____</p> <p><b>The basis for these orders is:</b> <input type="checkbox"/> Patient's preference    <input type="checkbox"/> Patient's best interest</p> <p style="padding-left: 40px;"><input type="checkbox"/> Other _____</p>	
<p><u>Signature of Physician/PA/NP (mandatory)</u></p>	<p><u>Physician/PA/NP Name (type or print)</u></p>	<p><u>Time and Date</u></p>
<p><b>FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED</b></p> <p style="font-size: small;">Use of original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid</p>		

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

<b>Section F</b>	<b>Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POLST Form</b>			
<p>I have given significant thought to life-sustaining treatment. I have expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following have further information regarding my preferences.</p>				
<p>Advance Directive                      <input type="checkbox"/> NO   <input type="checkbox"/> YES</p> <p>Court-appointed Guardian            <input type="checkbox"/> NO   <input type="checkbox"/> YES</p>				
<p><b>Review and discuss these orders if there is substantial change in my health status, such as:</b></p> <p>Advanced progressive illness                      Close to death                      Extraordinary suffering  Improved condition                      Permanent unconsciousness</p>				
<p><b>Signature of Patient/Resident, Parent of minor or Guardian/Healthcare Agent (optional)</b></p>				
<p><b>Signature of Person preparing form</b></p>		<p><b>Preparer Name (please print)</b></p>		<p><b>Date form prepared</b></p>
<b>Section G</b>	<b>Review of this POLST Form</b>			
	<b>Date</b>	<b>Reviewer</b>	<b>Location of Review</b>	<b>Outcome of Review</b>
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
<p><b>COMMENTS:</b></p>				