



State of Illinois
Department of Public Health

**IDPH UNIFORM PRACTITIONER ORDER FOR
LIFE-SUSTAINING TREATMENT (POLST) FORM**

For patients: Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional. **For health care providers:** Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.

PATIENT INFORMATION. For patients: Use of this form is completely voluntary.			
Patient Last Name		Patient First Name	
Date of Birth (mm/dd/yyyy)		Address (street/city/state/ZIP code)	
A Required to Select One	ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.		
	<input type="checkbox"/> YES CPR: Attempt cardiopulmonary resuscitation (CPR). Utilize all indicated modalities per standard medical protocol. (Requires choosing Full Treatment in Section B.)		<input type="checkbox"/> NO CPR: Do Not Attempt Resuscitation (DNAR).
B Section may be Left Blank	ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)		
	<input type="checkbox"/> Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.		
	<input type="checkbox"/> Selective Treatment: Primary goal is treating medical conditions with limited medical measures. Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.		
C Section may be Left Blank	<input type="checkbox"/> Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death. Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.		
	Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]		
D Section may be Left Blank	ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)		
	<input type="checkbox"/> Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.		
	<input type="checkbox"/> Trial period for artificial nutrition and hydration but NO surgically-placed tubes.		
E Required	<input type="checkbox"/> No artificial nutrition or hydration desired.		
	Signature of Patient or Legal Representative. (eSigned documents are valid.)		
	<input checked="" type="checkbox"/> Printed Name (required)		Date
	Signature (required) I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.		
F Required	<input checked="" type="checkbox"/>		
	Relationship of Signee to Patient:		<input type="checkbox"/> Agent under Power of Attorney for Health Care
	<input type="checkbox"/> Patient <input type="checkbox"/> Parent of minor		<input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list)
F Required	Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)		
	<input checked="" type="checkbox"/> Printed Authorized Practitioner Name (required)		Phone
	Signature of Authorized Practitioner (required) To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.		Date (required)
<input checked="" type="checkbox"/>			

****THIS PAGE IS OPTIONAL – use for informational purposes****

Patient Last Name	Patient First Name	MI
<p><i>Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient’s wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient’s care goals. This form can be changed to reflect new wishes at any time.</i></p> <p><i>No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.</i></p>		
Advance Directives available for patient at time of this form completion		
<input type="checkbox"/> Power of Attorney for Health Care	<input type="checkbox"/> Living Will Declaration	<input type="checkbox"/> Declaration for Mental Health Treatment
Health Care Professional Information		
Preparer Name	Phone Number	
Preparer Title	Date Prepared	

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient’s ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient’s health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient’s ongoing treatment and preferences; and
- a change in the patient’s primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write “VOID” across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

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| 1. Patient’s guardian of person | 5. Adult siblings |
| 2. Patient’s spouse or partner of a registered civil union | 6. Adult grandchildren |
| 3. Adult children | 7. A close friend of the patient |
| 4. Parents | 8. The patient’s guardian of the estate |
| | 9. The patient’s temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987. |

For more information, visit the IDPH Statement of Illinois law at <http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>

**HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT**