

# Provider Order for Life-Sustaining Treatment (POLST)

## Utah Life with Dignity Order

Bureau of Licensing and Certification, Utah Department of Health  
 State of Utah Rule R452-101, c.1 & 2 February 2019 (<http://health.utah.gov/rulemaking/forms.php>)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                      |                          |                                                                                                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Patient's Last Name                                                                                                                                                                                                                                                                                                                                                                                                                                               |              | First Name/Initials                  |                          | Effective Date of this Order                                                                                                                                                                                                       |  |
| Class of Patient                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Least of 104 | Address (owner's responsibility)     |                          |                                                                                                                                                                                                                                    |  |
| Medical Provider's Name (M.D./D.O./Nurse)                                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                      | Medical Provider's Phone |                                                                                                                                                                                                                                    |  |
| Briefly describe of patient's medical condition.                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Patient's desired goals:<br>Recommended care                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <b>A. CARDIOPULMONARY RESUSCITATION (CPR)</b> Treatment options when the patient does not have a pulse and is not breathing (check one):                                                                                                                                                                                                                                                                                                                          |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> Attempt to resuscitate (including attempt to resuscitate for symptoms indicating full treatment as per best fit) <input type="checkbox"/> Do not attempt resuscitation (DNR) (Allow Natural Death) <input type="checkbox"/> I do not wish to express a preference (withstanding this expressed treatment to resuscitate)                                                                                                                 |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <b>B. MEDICAL INTERVENTIONS</b> For patient who does not have a pulse and is not breathing (check one):                                                                                                                                                                                                                                                                                                                                                           |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> <b>FULL TREATMENT</b> (including life by all medically effective means. Medical care may include: endotracheal intubation, mechanical ventilation, defibrillation, cardiopulmonary resuscitation, and any other life-sustaining care that is required. Also includes medical care described below).                                                                                                                                      |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> <b>LIMITED MEDICAL INTERVENTIONS:</b> Treating medical conditions while avoiding burdensome measures. Medical care may include treatment of airway obstruction, cardiopulmonary resuscitation, resuscitation of cardiac arrest, or fluids, or antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit. |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> <b>COMFORT MEASURES:</b> 姑息性護理和/或姑息性護理。Medical care may include oral and body hygiene, immovable efforts to offer food and fluids only, medications, oxygen, positioning, restraints and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed in the current setting.                                                                                                |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> <b>NO PREFERENCE:</b> I do not wish to express a preference (withstanding this may lead to full treatment).                                                                                                                                                                                                                                                                                                                              |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Other instructions on interventions during the patient's end period if a final intervention is desired:                                                                                                                                                                                                                                                                                                                                                           |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <b>C. ARTIFICIAL NUTRITION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> Long-term artificial nutrition with feeding tube <input type="checkbox"/> Trial period of artificial nutrition with feeding tube <input type="checkbox"/> No artificial nutrition <input type="checkbox"/> I do not wish to express a preference                                                                                                                                                                                         |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Describe goals and/or time period if a trial is desired:                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <b>D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES</b>                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> Advance Directive available, entered and confirmed without conflict. <input type="checkbox"/> No Advance Directive available.                                                                                                                                                                                                                                                                                                            |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Health care agent named in Advance Directive                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                      |                          | Phone Number                                                                                                                                                                                                                       |  |
| <input type="checkbox"/> If the patient, with this order to serve as legal guidance, understands in some situations, the person making decisions for me may decide something different than what I would want with my preferences.                                                                                                                                                                                                                                |              |                                      |                          | <input type="checkbox"/> If the patient, with this order to serve as legal guidance, understands in some situations, the person making decisions for me may decide something different than what I would want with my preferences. |  |
| Described with:                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| <b>REQUIRED SIGNATURES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Print Name                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | Patient/health care agent if patient |                          | Signature                                                                                                                                                                                                                          |  |
| Signature of Medical Provider (M.D./D.O./Nurse) has signature required for review                                                                                                                                                                                                                                                                                                                                                                                 |              | Date/Time                            |                          | Date/Time                                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                      |                          |                                                                                                                                                                                                                                    |  |
| Signature of Health Care Agent (if named)                                                                                                                                                                                                                                                                                                                                                                                                                         |              | Date/Time                            |                          | Date/Time                                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                      |                          |                                                                                                                                                                                                                                    |  |

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