

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- This form should be completed by a health care professional based on the patient’s medical condition, and on the patient’s wishes, as expressed to the physician by the patient while in a competent condition, or in the patient’s advance directive, or by a representative of the patient acting with legal authority.
- This form should be signed by a physician, **and** also by the patient **or**, if the patient lacks decision making capacity, a representative acting with legal authority on behalf of the patient.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are valid.
- **Any incomplete section of POLST implies full treatment for that section.**
- Do not use a defibrillator (including AEDs) on a person who has chosen “allow natural death.”
- Always offer fluids and nutrition by mouth if medically feasible.
- Transfer the patient to a setting better able to provide comfort when it cannot be achieved in the current care setting (e.g., treatment of a hip fracture).
- A patient with capacity, or the authorized representative of a patient without capacity, may request alternative treatment.
- **Treatment of dehydration is a measure which prolongs life. A patient who desires IV fluids should indicate “Limited Additional Intervention” or higher level of care.**

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient’s health status, or (iv) the patient’s treatment preferences change. **If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A through D, write “VOID” in large letters with date and time, and sign by the line.** After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided, new form completed <input type="checkbox"/> Form Voided, no new form	
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided New Form Completed <input type="checkbox"/> Form Voided, no new form	

This form was prepared by the Georgia Department of Public Health pursuant to Official Code of Georgia Section 29-4-18(l). O.C.G.A. § 29-4-18(k)(3) provides: *“Any person who acts in good faith in accordance with a Physician Order for Life-sustaining treatment developed pursuant to subsection (l) of this Code section shall have all of the immunity granted pursuant to Code Section 31-32-10.” O.C.G.A. § 31-32-10 provides, in pertinent part: “Each health care provider, health care facility, and any other person who acts in good faith reliance ... shall be protected and released to the same extent as though such person had interacted directly with the [patient] as a fully competent person.”*