



Health care providers are authorized to print Oregon POLST Forms for use with their patients. The Oregon POLST Form remains a copyright protected document and in order to print the form certain guidelines must be followed.

### **Requirements and information for printing Oregon POLST Forms**

- The form must not be altered in **any way** including the overall layout, text, or images.
- Copy or print forms on 65# Cover Ultra Pink card stock\*
- Both side of the form must be printed back to back and not on separate pages
- A POLST Form requires a signature from an MD, DO, PA, or NP to be valid and should only be filled out and signed after an in-depth conversation between the patient and health care provider about the patient's goals of care
- The Oregon POLST Form is updated every two to three years. Please check back periodically to make sure that you are using the most current version of the form
- Forms differ from state to state depending on local laws and requirements. If you are a patient or provider outside of Oregon visit [www.polst.org](http://www.polst.org) to find out about POLST Programs and Forms in your state
- Written authorization is still required to reproduce the Oregon POLST Form for purposes other than patient care. To request authorization email [polst@ohsu.edu](mailto:polst@ohsu.edu).

If you have questions about the Oregon POLST Program or Oregon POLST Form visit [www.orpolst.org](http://www.orpolst.org)

\*Mohawk BriteHue Ultra Pink card stock is available online and at some retailers.

Suggested online vendors for Ultra Pink card stock:

Med-Pass - [www.med-pass.com](http://www.med-pass.com)

Boyd's Imaging Products - [www.iboyds.com](http://www.iboyds.com)

Mohawk Paper Store - [www.mohawkpaperstore.com](http://www.mohawkpaperstore.com)



**Information for patient named on this form PATIENT'S NAME:** \_\_\_\_\_

The POLST form is **always voluntary** and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.

**Contact Information**

Surrogate (optional):	Relationship:	Phone Number:	Address:
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**Health Care Professional Information**

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
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PA's Supervising Physician:	Phone Number:
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Primary Care Professional:

**Directions for Health Care Professionals**

**Completing POLST**

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at <http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf>.

**Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)**

**For the Oregon POLST Registry the following must be completed:**

- Patient's full name
- Date of birth
- Section A
- MD / DO / NP / PA signature
- Date signed

Send a copy of **both** sides of this POLST form to the Oregon POLST Registry.

FAX or eFAX:  
503- 418-2161

or  
Mail:  
Oregon POLST Registry  
CDW-EM  
3181 SW Sam Jackson Park Rd.  
Portland, OR 97239

Date Submitted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MAY PUT REGISTRY ID STICKER HERE:**

Registry Phone: 503-418-4083

\*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.

**Reviewing POLST**

This POLST should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change, or
- The patient's primary care professional changes.

**Voiding POLST**

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care. Information on the POLST program is available online at [www.orpolst.org](http://www.orpolst.org) or at [polst@ohsu.edu](mailto:polst@ohsu.edu).

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY**