TEXAS POLST TOOLKIT

A Guide for Health Care Professionals

TEXAS TALKS | Supporting Conversations That Matter

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Texas POLST Toolkit: A Guide for Health Care Professionals

Table of Contents

(The LaPOST, (Louisiana Physician Orders for Scope of Treatment, Handbook for Health Care Professionals and Washington POLST Clinician Toolkit were utilized in the development of these materials. Our thanks to them for these fine resources.)

This POLST Guide is a resource designed to help health care professionals (physicians, advanced practice professionals, nurses, social workers and/or clergy) engage with individuals, or their legal medical decision makers, to conduct a shared, decision-making conversation and complete a POLST meaningfully and effectively. It also provides details about treatment options to aid in care planning when treating a patient who presents with a valid POLST. We suggest you review this guide with a printed Texas POLST form, which can be found on the last page of this guide.

POLST Overview

POLST is a set of ***portable medical orders*** designed to communicate an individual's treatment wishes about the level of care they want to receive and about emergency care when the individual is unable to speak for themself. POLST is voluntary, portable, and actionable. Advance Care Plans differ from POLST. They are put in effect when a patient can no longer speak for themselves. POLST, as a medical order set, is in effect once it is completed and signed. Options selected on the POLST document should be reviewed by the provider and patient whenever a patient's condition changes, or when the setting they are being cared for changes, or at least annually.

The Law and Texas POLST

POLST is a portable medical order set. Although enabling legislation can sometimes lead to broader use of this way of working with patients facing serious, progressive illnesses, Texas POLST is adopted via clinical consensus that this is a meaningful and beneficial way to work with patients just as order sets typically are. It should be noted that many states have grown the use of POLST in this way.

Chapter 166 of the Texas Health and Safety Code contains the Texas Advance Directives Act and applies to POLST and advance directives. POLST does not replace an advance directive or living will but can be used to operationalize directives of the living will. EMS should honor and execute an OOH-DNR order or device [Tex. H&S Code, 166.102(b)], whenever "No CPR: Do Not Attempt Resuscitation" is selected. Although POLST conveys important information about a patient's treatment preferences, it does not replace a Living Will, MPOA, or OOH-DNR Order. A patient's Living Will, MPOA, or OOH-DNR Order controls over a POLST.

Chapter 166 of the Texas Health and Safety Code clarifies that any physician or health care professional acting under the supervision of or physician who honor an advance directive document are not subject to criminal prosecution, civil liability, or any other sanction because of following the orders. Health care institutions are encouraged to develop a policy and procedure for the use of POLST with the appropriate legal consultation. An example of such a policy can found on the Texas Talks website at www.texastalks.org under resources.

Intended Population

POLST is intended for individuals with a serious or chronic, progressive illness, or advanced frailty. Examples of medical conditions in which a POLST should be considered (not a complete list):

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
- Advanced Renal Disease
- Advanced Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson's Disease, ALS)

Here is a summary of the difference in use of advance directives and Texas POLST

	ADVANCE DIRECTIVE	Texas POLST
WHO?	Every Adult	Life-limiting illness regardless of age; frailty due to aging
WHAT?	Broad outline covering mostly resuscitation requiring interpretation and translation to a medical order	Specific physician's order

WHERE?	Needs to be provided by patient; no universal system	Travels with patient across health care settings

Completing a POLST: Section by Section

The front side of the POLST document contains the physician orders. The reverse side contains patient contact information and a description of how to use and void the document.

This guide will review key elements of each section of the POLST by category:

- Patient Information
- Section A. Cardiopulmonary Resuscitation Orders
- Section B. Initial Treatment Orders
- Section C. Additional Orders or Instructions
- Section D. Medically Assisted Nutrition
- Section E. Patient Signature
- Section F. Provider Signature
- Additional Contact Information
- Form Completion Details
- General Form Instructions

[Throughout this guide we will use a sample patient----Mary Simon---to help amplify the recommended procedures]

Step 1: Patient Information

It is important to complete this section as patient identifying information helps ensure correct identification of the individual.

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
Texas POLST Form: A Portable Medical Order (adapted from the National POLST form)

Medical Record # (Optional)

Health care providers should complete this form only after a conversation with their 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 (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information.	**Having a POLST form is always voluntary.**
This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form	Patient First Name: _____ Middle Name/Initial: _____ Preferred name: _____ Last Name: _____ Suffix (Jr, Sr, etc): _____ DOB (mm/dd/yyyy): ____/____/_____ State where form was completed:_____ Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

Step 2: Level of Care and Treatment Decisions

- ***Starting with Section B builds rapport for exploring difficult decisions by first exploring scenarios in which the individual has a pulse and/or is breathing. Section B translates the individual's goals of care into a level of care preference. Completing Section B first will help inform guidance on the CPR decision in Section A.***

- *Guide the individual in understanding the implications of their decisions within the context of their medical condition and prognosis.*

Section B: Initial Treatment Orders

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.	
Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.	
Pick 1	☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care. ☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. ☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

Treatment Preferences and Location of Care

Goals	**Longevity**	**Maintain Current Function / Level of Independence**	**Quality of Life / Relief of Symptoms**
Location of Care	Hospital + ICU	Hospital, Basic Care	Stay at home, Hospice
Treatment Level (Section B)	Full Treatment	Selective Treatment	Comfort-focused Treatment
Preferences	• Use all means to maintain life. • OK with invasive, aggressive measures. • Discuss time-trials.	• Treat treatable conditions. • Discuss all reasonable measures, including surgery.	• Arrange care at home. • Planning for end of life. • Transfer only if comfort not possible.

Let's explore a couple scenarios in which the individual has a medical emergency. Provide level of care options by describing the location of care delivery.

Scenario: *Mary Simon develops respiratory distress suddenly (e.g., pulmonary embolism or pneumonia); she suddenly has difficulty breathing and cannot speak for herself. Mary will need to know that she will be in distress, and she is at high risk of dying.*

- *Discussion:*
    - *Explain what "Full Treatments" entails, including being in the ICU, potentially having a breathing tube and being on a ventilator. Point out that being in the ICU and on a ventilator might meet her goal of keeping her alive until her family arrives. Also explain what "Selective" and "Comfort-Focused" treatments would entail. Confirm that she is willing to accept ICU-level care and be on a ventilator.*
    - *Time-limits are an important concept given Mary Simon's stated goal. "Agree to prolong life with machines to allow time for family to arrive." Discussion around time-limits is also beneficial.*

- *Decision:*
    - *Suggest "Full Treatments" in Section B.*
    - *Mary Simon may also indicate preferences in Section C: Additional Orders. In this situation, "Additional Orders" might be "intubation ok up to 2 weeks, only if improvement is clear, otherwise transition to Comfort-Focused Interventions".*

Scenario 2: *Mary Simon has had many hospitalizations in the last several months. After conversation, she indicates what she really wants is not to go back to the hospital. Her daughter is her primary support and caregiver and following the conversation, understands that peace and being at home with loved ones around her is really what her mother wants.*

- ***Discussion:***
    - ***Explain what Comfort-Focused Treatments means.***
        - ***It does not mean no care---rather it means doing things that keep the patient comfortable at home.***
        - *This can include medications to manage pain, ice to deal with dry mouth and other interventions. ○ Talk about what might occur that would indicate a trip to the hospital to re-gain comfort such as a painful infection.*

- *Decision: Suggest "Comfort-Focused Treatments" in Section B. In this situation, "Additional Orders" might be something as simple as "would like soft music playing".*

Section C: Additional Orders or Instructions

Sometimes, based on the discussion additional orders or instructions may be applicable. This can be a space to provide details about agreed upon time trials from Nutrition/Hydration, and/or dialysis as examples.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

Step 3: Cardiopulmonary Resuscitation Decision

- ***Match Resuscitation choices in Section A to range of treatment options selected in Section B.***

- *Guide the individual in understanding the implications of having CPR in the context of their medical condition. Address how the decisions made for Section B: Initial Treatment Orders, affect resuscitation choices. Use their goal and the decision in Section B as a basis for making a recommendation about whether to attempt CPR.*

- ***Be sure to obtain and complete a statutory Texas Out-of-Hospital-Do-NotResuscitate Form if "No CPR" is the selected choice.***

Section A: Cardiopulmonary Resuscitation Orders

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.		
Pick 1	☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)	☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B) *MUST Complete the Texas OOH-DNR form*

- *If an individual chooses "Full Treatments" in Section B:*
  - *Use shared decision-making to discuss the expected outcomes of CPR, given their medical condition**. Realize that "Full Treatments" can be matched with "YES CPR" or "NO CPR".*** ○ ***NOTE: Choosing "Yes CPR" in Section A requires the selection of "Full Treatments" in Section B.***

- *If an individual chooses "Selective Treatments" or "Comfort-Focused Treatments" in Section B:*
  - *Discuss how their Section B decision is inconsistent with having CPR.*
  - *Make medical recommendation: "NO CPR: Do Not Attempt Resuscitation" is indicated for these treatment preferences.*

- ***In Texas, a statutory Out-of-Hospital-Do-Not-Resuscitate form is required if the patient or patient representative elects, "No CPR: Do Not Attempt Resuscitation".***

This form can be found following the Texas POLST document in the back of this toolkit and/or at the following state of Texas website:

- *https://www.dshs.texas.gov/dshs-ems-trauma-systems/out-hospital-do-not-resuscitate-program*

Field Code Changed

- *If the patient's heart stops while hospitalized, the in-hospital orders may vary from POLST as hospital-based care can offer more immediate intervention and support. The POLST should be honored during admission to a hospital, but the admitting process should include a review of the individual's goals in the context of their current medical condition, including any new risks they may be facing.* ○ *Sometimes, a new POLST is appropriate, this means voiding the previous document, done by writing VOID in large print across the front of the document and completing a new POLST. It is the responsibility of the clinician to ensure that the electronic medical record contains this newer POLST document.*

Step 4: Choices about Medically Assisted Nutrition

- *This section is about preferences for medically assisted nutrition, otherwise known as artificial feeding or nutrition or tube feeding. Options are most often discussed in the context of other medical care, not during the delivery of emergency care. Patients may also have known wishes in their advance directives about medically assisted nutrition if they are no longer able to make their own decisions. As part of this conversation, review of advance directives to ensure consistency is highly recommended.*

- ***Medically assisted nutrition is proven to have no effect on length of life in moderate to late-stage dementia, and it is associated with complications.***

- *If a trial period is the choice selected, placing the time period of the trial in Section C: Additional Orders or Instructions is recommended.*

Section D: Medically Assisted Nutrition

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)		
Pick 1	☐ Provide feeding through new or existing surgically-placed tubes	☐ No artificial means of nutrition desired
	☐ Trial period for artificial nutrition but no surgically-placed tubes	☐ Not discussed or no decision made (provide standard of care)

Step 5: Signatures

- *Signatures are part of the confirmation process. Signatures are required to make this portable order set valid. It is helpful to summarize the discussion and check for agreement with the individual.*

- *Questions that are helpful include: "Can you tell me your understanding of the decisions we discussed?" "Do these decisions make sense given your preferences?"*

- *Also, helpful is to ask open ended questions such as, "What questions do you have?" and/or to revisit sections of the document.*

- *Lastly, it can be helpful to suggest the patient take some time to reflect on the discussion and arrange a follow-up visit to finalize later.*

- ***These orders are valid if e-signed by either the patient/patient representative and/or the physician.***

- *In Section E, the patient or patient representative signs. If someone besides the patient is signing it is helpful to note if they are acting as a surrogate on behalf of the patient in the blank designated "Authority" and to print their full name as well as signing.*

Section E: Patient or Patient Representative Signature

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)			
I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.			
✖ (required)			The most recently completed valid POLST form supersedes all previously completed POLST forms.
If other than patient, print full name:		Authority:	

- ***In Section F, the physician must sign this document providing their signature and printed full name as well as their license number. We are utilizing the National POLST model form and some states allow other clinicians to sign this document. In Texas, we do <u>not</u> have supervising roles allowing others to serve as the signer on this order so the "Supervising Physician Signature" blank can be ignored.***

Section F: Health Care Provider Signature

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.			
I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]			
✖ (required)		Date (mm/dd/yyyy): Required / /	Phone # : ( )
Printed Full Name:			License/Cert. #:
Supervising physician signature:	☐ N/A		License #:

Step 6: Additional Contact Information (Back Side of POLST form)

It is optional, but very helpful, to record the patient's emergency contact info, whether they are serving as a legal representative, the name and phone of their primary care provider and hospice information if the patient is enrolled in a hospice.

Contact Information: (Back side of Form)

Patient Full Name:		
Contact Information (Optional but helpful)		
Patient's Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)		
Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

- *It is also helpful to confirm that review of completed advance directives has occurred, or to note if for some reason, advance directives such as the Medical Power of Attorney and/or the Directive to Physicians and Families or Surrogates/Living Will were not reviewed. It is the best practice to ensure that the choices noted on the advance directives and the POLST match.*

- *Identify who participated in the discussion as well as naming any individual who serves as part of the health care team who assisted in conducting the conversation. This allows for easier understanding about questions the patient/family or the physician and care team members may have.*

Form Completion Information: (Back side of Form)

Form Completion Information (Optional but helpful)			
Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists		
Check everyone who participated in discussion:	☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____		
Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:		Date (mm/dd/yyyy): / /	Phone #: ( )
This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:			

- *Lastly, there is a section that contains other completion instructions and reminders.*
- ***And there is a reminder to complete the Out-of-Hospital-Do-Not-Resuscitate Order if No CPR: Do Not Attempt Resuscitation was selected in Section A.***

- *Finally, some institutions like to record other patient identifying information such as a barcode or Medical Record Number*

Form Information/Instructions – (Back side of Form)

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or to void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.texastalks.org
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info ***Complete TX OOH-DNR if No CPR is selected in Section A above.***	For Barcodes / ID Sticker

For more information, visit www.polst.org or www.texastalks.org Copied, faxed or electronic versions of this form are legal and valid. 2019

Sample Texas POLST Form

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Texas POLST Form: A Portable Medical Order (adapted from the National POLST model form)

Health care providers should complete this form only after a conversation with their 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 (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.texastalks.org

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/_____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B) ***MUST Complete the Texas OOH-DNR form***

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | **Authority:**

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/_____ | **Phone #:** (___)

Printed Full Name: | **License/Cert. #:**

Patient Full Name:

Contact Information (Optional but helpful)

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)		
Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document review: _____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists
Check everyone who participated in discussion:	☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or to void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.texastalks.org
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info ***Complete TX OOH-DNR if No CPR is selected in Section A above.***	For Barcodes / ID Sticker

Sample Texas Out-of-Hospital-Do-Not-Resuscitate Form

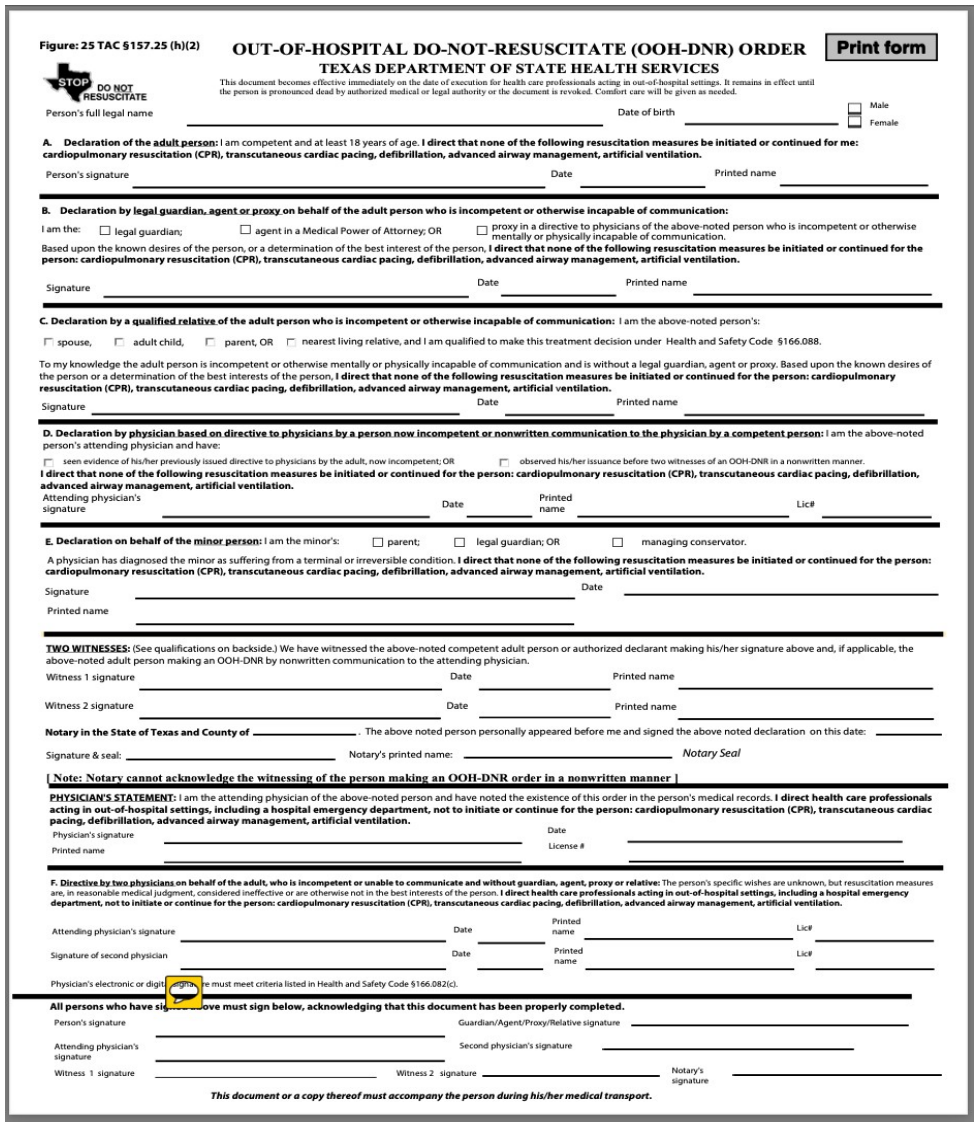

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print form

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.

Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state. [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

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