

Patient Information Concerning Advance Directives

What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that tell your doctor, health care professionals, family and friends your wishes about your health care ahead of time. There are also documents which can be used to appoint someone to make decisions for you if you cannot do so yourself. You can say “yes” to treatment you want and “no” to treatment you don’t want.

Types of advance directives available in Nevada are:

- **Durable Power of Attorney for Health Care**
This enables someone you name to make decisions concerning your health care if you become incapable of doing so yourself.
- **Declaration**
This directs any attending physician to withhold or withdraw treatment which only prolongs the process of dying, when you have an incurable and irreversible condition. There is also a declaration designating another person to decide to withhold or withdraw life-sustaining treatment.
- **Do-Not-Resuscitate Order**
Written by your physician at your direction, this advises health care professionals that you do not wish to undergo CPR if your heart stops beating or if you were to stop breathing.
- **Physician Order for Life-Sustaining Treatment**
This is a detailed document outlining the different types of life-sustaining treatments you would accept or refuse in certain situations.

Medical Treatment Terms

It is important to know the kinds of life-prolonging care to consider if using advanced directives. There are three kinds to consider: cardiopulmonary resuscitation (CPR), artificial provision of nutrition and fluids (tube-feeding), and active treatment to fight disease.

Life-resuscitating treatment

In Nevada, “life-resuscitating treatment” means cardiopulmonary resuscitation (CPR) or a component of CPR, including chest compressions, defibrillation, assisted ventilation, airway intubation, or administration of drugs or electric current to restore your heart’s rhythm.

Cardiopulmonary resuscitation is the act of reviving someone whose heart and/or breathing have stopped. CPR can include basic and advanced measures.

The basic measures are:

- Cardiac compression (repeatedly pressing on the chest to squeeze the heart so that blood begins to circulate again)
- Mouth-to-mouth breathing, to push air into the lungs

The advanced measures are:

- Intubation (putting a tube through the mouth or nose into the windpipe) and attaching a machine or device to do artificial breathing

- Defibrillation (powerful electrical shocks to the chest to start the heart beating again)
- Strong medications to correct the heart rhythm

The success of CPR depends on the individual's previous health and on how soon the procedure is started. The best results occur in a generally healthy person whose heart stops unexpectedly, and when CPR is started promptly. The chance of restarting the heart is much less likely when it has stopped as the result of many chronic problems.

Prompt CPR can save a person's life and prevent damage to the body's tissue and organs. On the other hand, brain damage is likely if more than about four minutes have elapsed before the procedure is started. Other risks include injuries to the chest and liver as a result of the force applied during chest compression.

Modern hospitals and nursing homes automatically attempt CPR on anyone whose heart and/or breathing stops, unless there is a Do Not Resuscitate - or "DNR" order - on file for the patient. A DNR order can only be written by a doctor with the permission of the patient, his or her health care agent or the family.

Artificial Provision of Nutrition and Fluids

Artificial provision of nutrition and fluids, also called "tube-feeding," is used either temporarily or permanently when patients are unable to swallow. There are three ways to provide artificial nutrition and fluids:

- The nasogastric tube, which is inserted through the nose into the stomach;
- The gastrostomy tube, which is inserted surgically through the stomach walls;
- Intravenous tubes, placed into veins in the arms or chest.

Nevada law permits individuals to refuse tube-feeding. However, some doctors are reluctant to withhold or withdraw tube-feeding from an unconscious patient unless the patient has left specific instructions to do so.

Death usually occurs within 2 to 14 days after tube-feeding is withheld or withdrawn. Many people worry that the lack of food and water will mean a painful death. Tube-feeding is most commonly withheld or withdrawn when people are unconscious or on the verge of death. At this state most patients have lost the desire for nourishment and the sensation of thirst or pain. As a precaution against discomfort, comfort care is routinely provided in the interim before death.

Active Treatment to Fight Disease

Active treatment to fight disease includes intensive treatment (the kind of high-technology care usually provided in hospital intensive care units) and non-intensive treatment. These are outlined below.

- Ventilators, commonly called respirators, are machines that can breathe for a patient if lung function is inadequate. This is done through a tube inserted into the windpipe via the nose or mouth or through a tracheotomy, a hole cut in the windpipe at the front of the neck.

Of the two procedures, passing a tube through the nose or mouth is the least comfortable because

it prevents the patient from speaking and eating, and it triggers the gag reflex. The tracheotomy, on the other hand, requires anesthesia and surgery, but eventually allows the patient to take food by mouth and to talk for short periods off the ventilator.

A ventilator is particularly helpful in getting a patient through a short-term crisis. It also has risks and can cause complications.

- Kidney dialysis involves the use of a machine to clean the blood when the kidneys no longer function properly. Dialysis takes several hours, several times a week, and can be quite uncomfortable.

Dialysis can be used on a temporary basis while a patient recovers from an acute illness or awaits a kidney transplant, or on a permanent basis in the case of more serious kidney problems. Complete kidney failure is a common part of the dying process.

- Invasive monitoring involves the use of intravenous lines (to administer drugs or fluids and to take blood samples) and catheters (to monitor heart and kidney function).
- Electrical pacemaker and other devices can be used to support the failing heart.
- Major surgery can be used to restore function or relieve pain.
- Antibiotics (available in pill form or by injection) to treat infections.
- Blood transfusion.
- Chemotherapy (a drug treatment) and radiation to fight cancer.

Questions and Answers

Do I have the right to make decisions about my medical care?

YES. NRS 449.680 provides that a patient retains the right to make decisions regarding the use of life-sustaining treatment, so long as he is able to do so. It provides that a patient has a right to refuse treatment to the extent permitted by laws and to be informed of the consequences of that refusal.

Do I have a right to refuse treatment?

YES. NRS 449.720 provides that you have the right to refuse treatment if you are able to make that decision and to be informed of the consequences of that refusal. A qualified patient may also forego life-sustaining treatment if he is able to do so. Sometimes a patient is so ill that he cannot refuse treatment. Therefore, it is very important to have an advance directive if you wish to refuse life-sustaining treatment during a terminal illness.

What is a Durable Power of Attorney for Health Care Decisions?

It is a signed, dated, and witnessed paper naming another person (such as a husband, wife, daughter, son, or close friend) as your “agent” or “proxy” to make medical decision for you if you should be unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid, such as surgery or artificial feeding.

What is a Declaration?

A Declaration generally states the kind of medical care you want (or do not want) if you become

unable to make your own decision. It is sometimes called a “living will” because it takes effect while you are still living. The Nevada Legislature has used the word “Declaration” as its preferred type of advance directive.

What is a Do-Not-Resuscitate (DNR) Order?

A DNR is a written directive issued by a physician, at your direction, that tells medical professionals not to perform CPR. That means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if you stop breathing or if your heartbeat stops.

CPR, when successful, restores the heartbeat and breathing and allows you to resume your previous lifestyle. The success of CPR depends on your overall health condition. When you are seriously ill or terminally ill, CPR may not work or may only partially work leaving you in a worse medical state than before the heart stopped. Some patients prefer to be cared for without aggressive measures when the end of life is imminent.

Do I have to write an Advance Directive under the law?

NO. It is entirely up to you.

Can I change my mind after I write any kind of advanced directive?

YES. You may change or cancel these documents at any time in accordance with state law. Any change or cancellation should be written, signed and dated in accordance with state law, and copies should be given to your family doctor, or to others to whom you may have given copies of the original.

If you wish to cancel an advance directive while you are in the hospital, you should notify your doctor, your family, and others who may need to know.

Even without a change in writing, your wishes stated in person directly to your doctor generally carry more weight than a Declaration or Durable Power of Attorney for Health Care Decisions, as long as you can decide for yourself and can communicate your wishes. But be sure to state your wishes clearly and be sure that they are understood.

What do I do with it once I've completed an advance directive?

You may keep a copy of your advanced directives in a secure, confidential “Living Will Lockbox” with the Nevada Secretary of State. This is readily available to you and your health care providers, when needed, 24-7. You choose who may have access to your documents filed in the Lockbox. Through your Lockbox, your health care provider may retrieve a copy of your advance directive during an emergency or illness. Begin the process at www.nvsos.gov.

Your advance directive is complete as soon as you have signed it and it is appropriately witnessed, if applicable. You can give it to your health care professional, or family or friends so that the form is available in case of emergency.

Must an institution where I am being cared for ascertain whether I have executed an advance directive?

YES. Federal law requires that the provider or organization must “document” in the individual’s medical record whether or not the individual has executed an Advance Directive.

You should not wait until you are old or facing a serious illness to think about these issues. Thinking about them while you are in good health gives you and your loved ones the opportunity to prepare for the sort of medical crisis that could happen to anyone at any time. You may also want to save a copy of your forms in an online personal health record.

If I am in a terminal condition (I am dying and there is no hope of a cure) and I am no longer able to make decisions regarding administration of life-sustaining treatment and have no advance directive, can life-sustaining treatment be withheld or withdrawn?

YES. If your spouse, an adult child or if more than one child, a majority of the adult children who are reasonably available for consultation, your parents, an adult brother or sister or, if there is more than one sibling (brother or sister) a majority of the adult siblings who are reasonably available for consultation, or the nearest other adult relative by blood or adoption who is reasonably available for consultation, in that order of priority, may in good faith and for your best interest, consent in writing attested by two witnesses to the withholding or withdrawal of treatment.

Who decides whether I am unable to make a decision regarding treatment?

Your attending physician.

May I make an oral advance directive?

NO. An Advance Directive must be a formal writing and must be signed by two witnesses. However, you may orally revoke an existing Advance Directive.

Is it advisable to discuss my advance directive with my health care provider?

YES. Unless your wishes are known by those involved in your health care, your wishes cannot be honored. It is advisable to provide a copy of the Advance Directive to your healthcare provider.

Should I discuss my plan to execute or not execute an Advance Directive with my lawyer?

YES. Your lawyer can explain the function and advisability of having an Advance Directive to you.

Should I discuss my Advance Directive with my family or loved one?

YES. It is advisable that those dear to you be aware of your wishes and where your original Advance Directive is so that your wishes can be carried out.

Where does Nevada law address advance directives?

Refer to these Nevada Revised Statutes:

NRS 449.600, 449.610 – Declaration

NRS 449.613 – Declaration, appoints another to make a Declaration should you be unable to

NRS 162A.700 – 162A.860 – Durable Power of Attorney for Health Care

NRS 450B.510 – 450B.525 – Do-not-resuscitate order

NRS 449.905 – Defines “advance directive”

What is a Physician Order for Life-Sustaining Treatment (POLST)?

A POLST form is a doctor’s order that helps you keep control over medical care at the end of life. Like a DNR order, the form tells health care providers which actions to take in the event of a medical emergency.

It tells them things like whether or not to administer CPR, to be taken to a hospital, whether or not you wish to receive artificial nutrition. Like a Do Not Resuscitate (DNR) order, the form tells emergency medical personnel and other health care providers whether or not to administer CPR in the event of a medical emergency. A POLST form may be used in addition to -- or instead of -- a DNR order. The POLST form may also provide other information about your wishes for end-of-life health care.

How does a POLST differ from other Advanced Directives?

A POLST form differs from a DNR order in one important way: A POLST form also includes directions about life-sustaining measures in addition to CPR, such as intubation, antibiotic use, and feeding tubes. It may also indicate whether you have chosen to donate your organs after death. The POLST form helps medical providers understand your wishes at a glance, but it is *not* a substitute for a properly prepared health care declaration (living will) and durable power of attorney for health care.

How do I make a POLST form?

A doctor can help you create a POLST form if you enter a medical facility or health care setting such as a hospital, nursing home, or hospice care in a facility or at home. The form is legally valid only if explained and signed by the doctor. If a member of the medical staff does not ask you whether you want to create a POLST form, you may ask for one.

Where does Nevada law address POLST?

Refer to these Nevada Revised Statutes:

NRS 449.6942

The following is the form of a "Declaration," provided for under Nevada Statutes:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration |____|

Signed this _____ day of _____, 19____.

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

The following is the form of a "Declaration," provided for under Nevada Statutes **designating another person** to decide to withhold or withdraw life-sustaining treatment:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint _____, or if he or she is not reasonably available or is unwilling to serve, _____, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to NRS 449.535 to 449.690, inclusive. (If the person or persons I have so appointed are not reasonably available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) *Strike language in parenthesis if you do not desire it.*

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration | _____ |

Signed this _____ day of _____, 19_____.

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

Name and address of each designee.

Name: _____

Address: _____

Name: _____

Address: _____

The following is the form of a “Durable Power of Attorney for Health Care Decisions” provided for under Nevada Statute:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing the document you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. The power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.
3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior Durable Power of Attorney for Health Care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, _____(insert your name) do hereby designate and appoint:

Name:

Address:

Telephone Number:

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date:

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

- a. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.....|____|
- b. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.).....|____|
- c. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed.).....|____|
- d. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld.....|____|
- e. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.....|____|

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want and circling the answer you prefer.

Other or Additional Statements of Desires:

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to service in the order listed below:

A. First Alternative Attorney-in-Fact

Name: _____
Address: _____
Telephone Number: _____

B. Second Alternative Attorney-in-Fact

Name: _____
Address: _____
Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for HealthCare on _____ (date)
at _____ (city), _____ (state).

(Signature)

(This power of attorney will not be valid for making health care decisions unless it is either (1) signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or (2) acknowledged before a notary public.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of statement of witnesses.)

State of Nevada)
 : ss:
County of _____)

On this _____ day of _____, in the year _____, before me, _____(here insert name of notary public) personally appeared _____(here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness (1) a person you designate as the attorney-in-fact; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and the to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature: _____

Names: _____ Address: _____

Print Name: _____

Date: _____

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

NEVADA POLST (Physician Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY
 Faxed, copied or electronic versions of a Nevada POLST are legal and valid

SIDE 1: Medical Orders

Consult this form when patient lacks decisional capacity. It is intended to be honored by any health-care provider who treats the patient in any health-care setting, including, without limitation, a residence, health care facility or the scene of a medical emergency (NRS 449.694.). A section not completed does not invalidate the rest and indicates full treatment for that section.	Last Name/First/Middle Initial		
	Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
	/ /	_____	M F

Section A CPR Check one only	CARDIOPULMONARY RESUSCITATION (CPR). <i>Patient/resident has no pulse & is not breathing.</i> <input type="checkbox"/> Attempt Resuscitation (CPR) (See Section B: Full Treatment required)	<input type="checkbox"/> Allow Natural Death (Do Not Attempt Resuscitation) If available, EMS-DNR #: _____
	When not in cardiopulmonary arrest follow orders in Section B	

Section B Interventions	MEDICAL INTERVENTIONS. <i>Patient/resident has pulse and/or is breathing.</i> Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.
	1. <input type="checkbox"/> Comfort Measures Only. The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth as tolerated, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. Transfer only if comfort needs cannot be met in current location. <i>Other Instructions:</i> _____
	2. Limited Medical Interventions. Comfort measures always provided. a. Life-Sustaining Antibiotics. <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms <input type="checkbox"/> Administer antibiotics by mouth as necessary <input type="checkbox"/> Administer antibiotics IV as necessary <i>Other Instructions:</i> _____ b. Artificially Administered Fluids and Nutrition. <input type="checkbox"/> No feeding tube <input type="checkbox"/> Defined trial period of feeding tube <input type="checkbox"/> Long term feeding tube <input type="checkbox"/> No IV fluids <input type="checkbox"/> Defined trial period of IV fluids <input type="checkbox"/> Long term IV fluids <i>Other Instructions:</i> _____ c. Other Limitations of Medical Interventions. <input type="checkbox"/> No intensive care admission <input type="checkbox"/> No x-ray <input type="checkbox"/> No IV (assure agreement with a. & b. above) <input type="checkbox"/> No hyperalimentation <input type="checkbox"/> No electrolyte or acid/base corrective measures <input type="checkbox"/> No lab work <input type="checkbox"/> No antiarrhythmic drugs <input type="checkbox"/> No dialysis <i>Other Instructions:</i> _____
3. <input type="checkbox"/> Full Treatment. Includes care above plus endotracheal intubation and cardioversion. <i>Additional Instructions:</i> _____	

Section C Physician Signature	Date (Required)	Physician Signature (Required)	Physician Name (Print)
	Physician Office Address	Physician Phone	Physician License No.

Send original with patient when discharged or transferred

NEVADA POLST (Physician Order for Life-Sustaining Treatment)

Patient Name: _____ **DOB:** _____

SIDE 2: Supplementary Patient Preferences

<p>Section D Organ Donation</p>	<p>ORGAN DONATION <input type="checkbox"/> I have documented on my license or state issued ID that I would like to donate my organs <i>Other Instructions:</i> _____</p>
<p>Section E Advance Directive</p>	<p>The following documents/persons have further information regarding patient's/resident's preferences:</p> <p>1. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney (DPOA) for Health Care <input type="checkbox"/> NO <input type="checkbox"/> YES If no AD, skip to #2 below</p> <p>AD Registered with Secretary of State: <input type="checkbox"/> NO <input type="checkbox"/> YES - Registration No: _____ Other location: _____ Appointed Agent #1: _____ Telephone No: _____ Appointed Agent #2: _____ Telephone No: _____</p> <p>2. If no agent appointed, another person will make decisions for you as determined by Nevada law.</p> <p>3. Court-Appointed Guardian <input type="checkbox"/> NO <input type="checkbox"/> YES Name: _____ Telephone No: _____</p>
<p>Section F Signatures</p>	<p>Patient / Agent / Parent / Guardian (circle one) Approval I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences.</p> <p>Signature: _____ Date: _____</p> <p>Consent for Sections A and B above were discussed with and given by:</p> <p> <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Adult Child <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent (DPOA) <input type="checkbox"/> Other: _____ </p> <p>Witnessed by (for any checked above): _____ Date: _____</p> <p>Preparer's Information</p> <p>Preparer's Name (print): _____ Date: _____ Signature of Person Preparing Form: _____</p>
<p>Section G Registry</p>	<p>Physician initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox. Authorization forms can be found at: www.LivingWillLockbox.com.</p> <div style="border: 1px solid black; width: 80px; height: 40px; margin-left: auto; margin-right: auto;"></div>
<p>GENERAL INSTRUCTIONS</p> <ul style="list-style-type: none"> Record all treatments entered on this POLST as orders in patient's chart. Copy POLST form for patient record. If orders change complete a new POLST and write VOID across this POLST. If no new form is completed, full treatment and resuscitation may be provided. Transfer or discharge patient with a current POLST form. <p>WHEN THIS FORM SHOULD BE REVIEWED</p> <p>This form (POLST) should be reviewed periodically and if:</p> <ul style="list-style-type: none"> The patient/resident is transferred from one care setting or level to another, or There is a substantial change in patient/resident health status, or The patient/resident treatment preferences change. <p>THE LATEST VERSION OF THE POLST FORM IS AVAILABLE FROM THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH.</p>	
<p>Send original with patient when transferred or discharged</p>	

For Internal Use