



MERRILL GARDENS

A one of a kind retirement community

Please FAX back to: Merrill Gardens at Campbell FAX #: 408-370-6458

PRN AUTHORIZATION LETTER

Dear Dr. _____

Re: Your patient: _____

To receive nonprescription PRN medications, state licensing requires that either:

- 1) your patient be capable of determining his/her own need for medication, or
- 2) for non-prescription medication only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or, clearly communicate the symptoms for a nonprescription medication then you, the physician, must be contacted before the PRN medication can be given. Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine his/her own need for PRN medications and inform you of any changes which indicate he/she can no longer make these decisions.

Thank you for your assistance.

Sincerely,

Signature

Emily Brown, MD

Title

RCO

Telephone number

408-370-6454

Date

11/12/16

Please check which circumstance describes your patient and fax back. Thank you.

- My patient can determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.
- My patient cannot determine his/her own need for nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.
- My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot communicate his/her symptoms indicating a need for a nonprescription medication. (Requires contact with Physician prior to each dose)

The following prescription and nonprescription medications can be taken on a PRN basis:

Physician's Signature: _____

Date: _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY



Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

| | |
|----------------------|------------------------------|
| Patient Last Name: | Date Form Prepared: |
| Patient First Name: | Patient Date of Birth: |
| Patient Middle Name: | Medical Record #: (optional) |

EMSA #111 B
(Effective 1/1/2016)*

A **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)

Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

Check One

Full Treatment – primary goal of prolonging life by all medically effective means.
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Trial Period of Full Treatment.

Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

Request transfer to hospital only if comfort needs cannot be met in current location.

Comfort-Focused Treatment – primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: _____

C **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

Check One

Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

Trial period of artificial nutrition, including feeding tubes. _____

No artificial means of nutrition, including feeding tubes. _____

D **INFORMATION AND SIGNATURES:**

Discussed with: Patient (Patient Has Capacity) Legally Recognized Decisionmaker

Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
 Advance Directive not available Name: _____
 No Advance Directive Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

| | | |
|---------------------------------------|--------------------------|-------------------------------------|
| Print Physician/NP/PA Name: | Physician/NP/PA Phone #: | Physician/PA License #, NP Cert. #: |
| Physician/NP/PA Signature: (required) | | Date: |

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

| | |
|--|---------------------------------------|
| Print Name: | Relationship: (write self if patient) |
| Signature: (required) | Date: |
| Mailing Address (street/city/state/zip): | Phone Number: |

**FOR REGISTRY
USE ONLY**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**Patient Information**

| | | |
|-----------------------------|----------------|------------------------------|
| Name (last, first, middle): | Date of Birth: | Gender: M F |
|-----------------------------|----------------|------------------------------|

NP/PA's Supervising Physician

Name:

Preparer Name (if other than signing Physician/NP/PA)

Name/Title:

Phone #:

Additional Contact None

Name:

Relationship to Patient:

Phone #:

Directions for Health Care Provider**Completing POLST**

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- 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.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED