CAJON MEDICAL GROUP PC

Internal Medicine

5475 Walnut Ave 2nd Floor Chino CA 91710

Phone (909) 255-0806 | **Fax (909)312-6652**

PATIENT INFORMATION SHEET

PLEASE PRINT

Today's Date: _____

Personal Information

PATIENT NAME_____ D.O.B_____
LAST FIRST MI

Language _____ Sex _____ Marital Status_____

Race_____ Religion_____ Ethnicity_____

HOME PHONE ( )_____ CELL( )_____ E-MAIL_____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

Insurance Information

Primary Insurance	Subscriber ID
Subscriber Name	Date of Birth

Employer

Secondary insurance	Subscriber ID
Subscriber Name	Date of Birth

Emergency Contact

Contact Name	Relationship	Phone Number
Home Address	Apt, Space, Unit	
City	State	Zip

Pharmacy Information

Pharmacy Name	Phone Number
Address (cross streets)	City

RX History Consent: I hereby authorize CAJON MEDICAL GROUP PC to obtain my previous prescription/medication through external sources. _____ (initials).

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits, otherwise payable to me, to CAJON MEDICAL GROUP PC. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at time of service and/or deductible, additional fees for form processing, returned check, Copying of medical record, And missed appointments that may apply. If this account is

Signature: _____ Date: _____

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Communication Consent Agreement for the Release of Medical Information

I understand that under federal law. Health Insurance Portability and Accountability Act (HIPPA), this medical office may Not release any medical information to any individual without my expressed and written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore, give permission to this office to release medical information on my behalf to the following person(s):

First Name	Last Name	Relationship
Phone number	Age	Date of Birth
Address(number and street) Apt, Space, Unit		
City State Zip		
Form(s) of Identification to be Used (DL,ID,SSN,ECT)		

First Name	Last Name	Relationship
Phone number	Age	Date of Birth
Address(number and street) Apt, Space, Unit		
City State Zip		
Form(s) of identification to be Used (DL,ID.SSN.ECT)		

Authorized Methods of Communication (check all that apply)			
Residence Telephone	Work Telephone	Written Correspondence	Other (specify)
No.( )	No.( )	Mail/Delivery Service	
Leave call back number only; do not leave message	Leave call back number only; don't leave message	Fax( )	
Okay to leave detailed message with person	Okay to leave detailed message with operator	Residence e-mail	
Okay to leave detailed message on answering machine	Okay to leave detailed message on personal voice mail	Work e-mail:	

Patient Signature: _____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Your health information may be used to seek payment form your health plan, form other sources of coverage such as an automobile insurer, or from credit card companies that you might use to pay for service. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.
Your health information may be disclosed to public health agencies as required by law. Your health information will be used by our staff to send you appointment reminders.

Disclosures of our health information or its use for any other purpose other than those listed above requires your specific written authorization you decide to change your mind after signing an authorization you may submit a written revocation of the authorization.

You have the right to inspect your medical information by submitting a request in writing to the office of CAJON MEDICAL GROUP PCand a time will be set up for you to examine your char. Your request will be reviewed and will generally be approved unless there are legal or medical reason to deny the request. If there is a complaint you may send a letter outlining your concerns to CAJON MEDICAL GROUP PC office, attention: office Manager.

As permitted by law. We reserve the right to amend or modify our privacy policies and practice. These changes in our policies and practice may be required by changes in federal and state law and regulation. A more detailed version of the notice can be given to you upon request. You may also receive a copy of this notice upon requested.

_____

Patient Name

_____

Patient Signature

_____

Date

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. CAJON MEDICAL GROUP PC will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payment amounts may vary during the course of treatment, as outlined by your plan. Co-payments are due and payable at each appointment. The co-payment amount set by your plan for each visit is as follows:

If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. You are responsible for obtaining any prior authorization for treatment from your insurance carrier. For special modalities of treatment not covered by your benefit plan, a written agreement will be signed between you and your clinician. This agreement should cover the fees and treatment plan and should never contain fees more than the fee-for-service discount rates that your benefit plan provides.

<u>Miscellaneous Fees:</u>
There will be a charge of

$10.00- $25.00 per page for all forms requiring completion
$10.00- $25.00 (varies upon documents) for all disability paperwork
$50.00 Letter writing

Please sign below indicating your understanding of CAJON MEDICAL GROUP PC's financial policy:

Patient or Guardian's Signature_____ ____Date_____

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Consumer Notice of Rights and Responsibilities

Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and member's right and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all health care professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates – as stated in your Policy and/or Certificate.
  - The medications prescribed for your – what they are for, how to take them properly and possible side effects.

Continuous Improvement

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
  - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

Eligible Employee Accountability/Autonomy

- As a partner in your own health care, you have the right to refuse treatment – providing you accept responsibility and the consequences of such a decision—and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- You also have the responsibility to:
  - If you have PacifiCare Insurance identify yourself as such when receiving behavioral health services.
  - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
  - Be on time for all appointments and to notify your provider's office as far in advance as possible if your need to cancel or reschedule an appointment.
  - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from Managed Care Company, if applicable.
  - Notify your behavioral health plan within 48 hours – or as soon as possible—if you are hospitalized or receive emergency care.
  - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at any and all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

If you have any questions or complaints regarding your rights, contact the Member Service Associated with your insurance company.

Patient or Guardian's Signature _____ Date _____

Signature _____ Date _____

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Health Disclosure Form

Limits of Confidentiality Statement

- All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:
  1. The patient authorizes a release of information with a signature.
  2. The patient's medical condition becomes an issue in a lawsuit.
  3. The patient presents as a physical danger to self (*Johnson v County of Los Angeles, 1983*).
  4. The patient presents as a danger to others (*Tarasoff v Regents of University of California, 1967*).
  5. Child or Elder abuse and/or neglect are suspected (*Welfare & Institution and/or Penal Code*).

  In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

- All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion is not to be discussed outside of the counseling sessions. **Initial here:**_____

Release of Information

- I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here:**_____

Emergency Access

- Practitioners are available after hours to handle emergencies. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner. **Initial here:**_____

Consent for Treatment

- I authorize and request my practitioner carry out psychological exams, treatment and /or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me..
  Initial here: _____

Patient/Guardian Signature _____Date _____

Practitioner Signature _____ Date _____

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ASSIGNMENT OF BENEFITS

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to the Provider of service for Medical health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

_____

Signature of Patient, Legal Guardian/Legal Representative

_____

Name (Printed)

PATIENT ACKNOWLEDGEMENT of
NOTICE OF PRIVACY PRACTICES

I, _____ have received

Patient Name (Please Print)

The **Notice of Privacy Practices,** and understand that **CAJON MEDICAL GROUP PC**, Inc. has certain legal duties to safeguard my Protected Health Information. (PHI). I also understand that I have certain rights in regard to my (PHI).

_____

Signature Date

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SYMPTOMS IDENTIFICATION and HEALTH HISTORY

New Patient Medical History* - *Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Hypertension		Arthritis	
❑ High Cholesterol		Stroke(CVA)	
❑ Hypothyroidism (low thyroid)		Other(s):	
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr.*	*Operation / Hospitalization / Injury*	*Month / Yr.*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

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♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Do you take recreational Drugs	Which one?	Duration-
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr.		*Month/Yr.*		*Month/Yr.*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	

ACKNOWLEDGEMENT

PHVSICIAN:_____ **TELEPHONE:**_____

ADDRESS:_____

_____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **TELEPHONE:**_____

ADVANCED DIRECTIVES

THIS ACKNOWLEDGEMENT THAT THE PHYSICIAN, OR ONE OF HIS/HER STAFF **MEMBERS,** HAS PROVIDED MEINFORMATION CONCERNING ADVANCED DIRECTIVES.

1. I AM AGE 18 OR OLDER (CIRCLE ONE) YES NO

2. I UNDERSTAND I HAVE THE OPTION OF PUTTING TOGETHER ADVANCED DIRECTIVES FOR MY HEALTHCARE. MY PHYSICIAN HAS PROVIDED ME WRITTEN INFORMATION CONCERNING THEIR ADVANCED DIRECTIVES. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE MYDOCTOR(S) WITH ANY DOCUMENTS THAT ARE REQUIRED TO **CARRY** OUT MY ADVANCED DIRECTIVES.

3. I AM AWARETHATAOVANCEO DIRECTIVES MAY BEANY OF THE FOLLOWING:
   A; A DURABLE POWER OF ATTERNY FOR H EALTH CARE.
   B: THE DECLIRATION IN THE A NATURAL DEATH ACT-EX. A LIVING WILL
   C: I MAY WRITE MY WISHES ON PAPER SO THAT MY FAMILY MAY USE THE DOCUMENT IN DECIDING MY MEDICAL TREATMENT IN THE EVENT I AM UNABLE TO DO SO.

PATIENT'S SIGNATURE:_____ **DATE:**_____

THIS DOCUMENT WILL BE PART OF **MY MEDICAL RECORD.**

What is a POLST?

Key Facts About POLST for Individuals and Family Members

Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.

- **POLST is for people who are seriously ill or have advanced frailty**. If you are healthy, an advance directive is for you.

- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.

- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.

- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician, nurse practitioner, or physician assistant.**

- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST**. Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.

- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.

- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.

- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

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)*

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.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D — INFORMATION AND SIGNATURES:

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

☐ Advance Directive dated _____, available and reviewed →

☐ Advance Directive not available

☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
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:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 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	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	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