

Patient  
Name: \_\_\_\_\_

## Informed Consent, Attending Designation, and Hospice Election Statement

### Election:

I, \_\_\_\_\_, choose to elect Inspiration Hospice-A Step Forward Company ("Inspiration") as my hospice provider. I and my caregiver/family request that Inspiration assume the professional management of patient care.

I hereby authorize hospice services, provided by Inspiration Hospice, to begin on \_\_\_\_\_ Date

I am electing to use the following insurance:

\_\_\_\_\_ Medicare Hospice Benefit

\_\_\_\_\_ Medicaid Hospice Benefit

\_\_\_\_\_ Private Insurance

**Office Use Only:**

Benefit Period: \_\_\_\_\_

**Medicare/Medicaid Hospice Benefit Election:** I understand that The Hospice Medicare Benefit Program booklet will be provided with my admit paperwork.

I hereby elect to receive the Medicare Hospice Benefit from Inspiration. Inspiration will provide services, medications, and durable medical equipment related to my terminal diagnosis. I understand that once the Medicare/Medicaid Hospice Benefit starts, Original Medicare/Medicaid will cover the cost for hospice if it is related to my terminal illness. I understand that by electing to receive the Medicare/Medicaid Hospice Benefit that Inspiration will not provide/cover the following:

- Hospice care provided by any other hospice other than Inspiration (unless this is provided under arrangements made by Inspiration.)
- Treatment intended to cure my terminal illness and/or related conditions.
- Prescription drugs unless these drugs are for symptom management of my illness or to control pain.
- Care from any provider that was not set up by Inspiration's medical team.
- Room and board.
- Outpatient/Inpatient hospital care, including: emergency room visits and ambulance transportation. (Unless it is arranged by your hospice team for general inpatient stays.)

General Inpatient Stays: Short-term inpatient palliative care is provided directly by the hospice in a hospital and/or skilled nursing facilities with which Inspiration has contracted. To assure continuation of my hospice benefit and the continuity of my plan of care, I only choose to receive short-term inpatient care at an Inspiration contracted facility, or I can choose to revoke the Medicare/Medicaid Hospice Benefit. If general inpatient care is deemed necessary by the hospice staff, Inspiration will set up these services.

**Private Insurance Authorization:** I hereby authorize any insurer or other organization from whom I am entitled to receive payment for hospice services, to make payment for such services directly to Inspiration.

**Financial Responsibility:** I have read the explanation regarding benefits, provisions, and the scope of services. I understand that efforts will be made to recover cost of care through Medicare, Medicaid, or private insurance. However, I understand that I will not be denied admission to hospice if I am unable to pay.

Patient  
Name: \_\_\_\_\_

**Attending Designation:** I acknowledge that hospice services are limited to palliative care and that I am not being offered a “cure” for my illness. I understand that should I choose to pursue aggressive treatment for my illness; I may be eligible to receive care from another provider of services. The hospice team will work closely with me and my attending physician to design and implement a palliative plan of care.

I designate my attending physician to be Dr. \_\_\_\_\_. My signature on this form acknowledges that the identified attending physician is my choice. I understand that Medicare/Medicaid will pay for hospice services provided by my attending physician if the physician is not an employee of, nor receiving compensation for those services from Inspiration. I understand that Inspiration Hospice is financially responsible only for the service included on my hospice plan of care. If I do not agree with the recommended hospice plan of care or wish to seek treatment, I understand that I may choose to revoke the Medicare Hospice Benefit at any time.

**OFFICE USE ONLY - Attending has been verified:**                      Yes                      No

**Preferred Drug List:** I have been informed that Inspiration uses a Preferred Drug List. I also understand that Inspiration will provide medication related to my prognosis, per the formulary. I also understand that hospice does not cover all medications. I understand that I can choose to pay for medications not covered by Inspiration.

**Understanding of Hospice:** I understand that Inspiration is a palliative care program and not curative in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort. Inspiration will also provide means to address the spiritual and emotional stress which may accompany a terminal illness through chaplains and social workers. I also understand that every attempt will be made to preserve my personal dignity with the help of the nursing staff.

**Definition of Family and Unit of Care:** I understand that Inspiration focuses on both my care and the care of my loved one, as defined by me.

**The Caregiver and 24-Hour Care:** I understand that Inspiration is not intended to take the place of care provided by a family member, a loved one, private duty caregiver, or facility staff but be an added support to the care already in place. I understand that Inspiration Hospice does not provide 24-hour care. If 24-hour care is needed, I understand that it is up to myself or my designated care giver to make arrangements for this type of care. I understand that Inspiration will continue to follow my care in whatever setting the I may move to, if my location is within Inspiration Hospices geographic coverage area. I understand that if my home is in a facility, care will be provided by facility staff in collaboration with Inspiration staff.

I have asked \_\_\_\_\_ to be my designated caregiver.

**Health Care Power of Attorney:** I have provided Inspiration with a copy of the Utah Advance Health Care Directive. I understand that I have the right not to choose an agent. I also understand that I can revoke my agent at any time. I also understand that my designated caregiver can be a different person than my Health Care Power of Attorney.

**Plan of Care:** I understand that both I and my designated care giver will participate in decisions about the care provided by the hospice care. I also understand that my designated care giver will receive training and support when it is needed to manage my ongoing care. I understand that my plan of care will be reviewed every 15 days by the hospice team. I understand that I can review my plan of care if requested in writing. I also understand that I can refuse a particular treatment or service offered at any time.

Patient  
Name: \_\_\_\_\_

**Patient Choice of Care:** I understand that I have the choice about how, where, and who provides my care. I also understand that I have the right to name my Financial Power of Attorney, Health Care Power of Attorney, and make my resuscitation wishes known. I understand that if I do not currently have these documents; an Inspiration professional can assist me with completing them.

**Election Periods:** I understand by electing to use the hospice benefit, I am entitled to hospice care for two (2) election periods of ninety (90) days each. Thereafter, I will receive unlimited sixty (60) day periods, based on Medicare Hospice eligibility requirements.

**Discharge:** I understand that if my condition stabilizes or improves, I may be discharged from Inspiration. I understand that I must meet Medicare eligibility requirements to stay on service. I understand that prior to discharge the hospice team will assist my family and I with discharge planning. I also understand that if my condition changes, I can request to be readmitted at a later date.

**Revocation:** I understand that I may revoke this Consent/Election and withdraw from hospice treatment at any time by signing a Revocation Statement, which will be given to me upon my request. If I revoke this election, I understand that I will forfeit any remaining days in the election period but will be eligible for benefits previously waived by my electing to use hospice. I may opt to re-elect my hospice benefit at a later date, if eligible.

**Informed Consent:** My signature on this form certifies that I have been provided with a through explanation of services provided by Inspiration Hospice and that I consent to receive care. I have received, reviewed, and been educated on the following:

- Welcome Letter/Hours of Operation
- Admission Information/Eligibility Requirements for Hospice
- Why Inspiration Hospice is Unique
- Service Provided
- Home Use and Disposal of Controlled Substance Policy
- Patient Rights and Responsibilities
- Nondiscrimination Policy and Grievance/Complaint Process
- The Medicare Hospice Benefit
- Signs and Symptoms of Approaching Death Instruction Sheet
- Infection Control
- When to Call
- Family Disaster Plan Education
- Home Safety Guidelines
- Emergency Preparedness/Risk/Disaster Evaluation
- Authorization to Release Medical Information
- Durable Medical Equipment Form
- Patient Authorization to Disclose Protected Health Information/Notice of Privacy
- Aide Plan of Care
- End of Life Planning:
  - Advance Health Directive
  - Durable Power of Attorney (POA)
- Provider Order for Life Sustaining Treatment (POLST)
- Informed Consent, Attending, Election

**Consent to Regulatory Surveyor Visits:** I consent to receive visits from healthcare professionals and hospice accrediting or regulatory surveyors that are authorized by Inspiration to observe my care. I also consent to be interviewed by these individuals.

**Consent to Disclose My Location:** I give Inspiration permission to disclose my location and medical condition to their personnel to further my care.

**Bereavement Care for My Loved Ones:** I understand that after my passing, my loved ones will be offered bereavement from an Inspiration Hospice professional. Bereavement services include counseling, support groups, phone contacts, mailings, and memorial services.

Patient  
Name: \_\_\_\_\_

**Photo Release:** I understand that mine or my loved one's image may be used for medical purposes. I understand that every safeguard is in place to protect these images and my privacy. I also understand that my image will not be used for promotional purposes without my written consent.

**Release for Memorials:** I give Inspiration permission to use my photograph or a digital image and my name at future memorials and to alter the same without restriction. I further agree that my name or identity may be revealed in descriptive text or commentary in connection with the memorial. I understand and agree that any of the memorial literature using my likeness including negatives, prints and digital reproductions thereof will become property of Inspiration and will not be returned. I hereby hold harmless, release, and forever discharge Inspiration, its agents, and employees, from any and all claims, demands, and liabilities whatsoever in connection with this authorization. I, or my surrogate, am at least 18 years of age, and am competent to contract in my own name. I have read this release before signing it, and fully understand the contents, impact and meaning of the release.

\_\_\_\_\_ **Opt-Out of Memorials:** By initialing this section, I am opting out of having my name and image used at Inspiration's future memorials.

**Complaints:** If I have complaints or problems, I can call the administrator at 801.281.1314 without fear of any retaliation, loss of services and/or benefits. If I do not feel my problem is resolved, I may register a complaint with the Utah Department of Health Facility Licensing, Certification, and Resident Assessment by calling their hotline at 1.800.999.7339.

**Records:** I authorize Inspiration to obtain copies of medical and billing records and keep such records, which may include necessary information about my medical condition and my finances during my time on hospice. I understand that Inspiration Hospice will use these records for the purpose of providing treatment, obtaining payment for care, and conducting health care operations. I also understand that Inspiration has established policies to safeguard against unnecessary disclosure of my private health and financial information.

**Consent to Treat:** I certify that I have read and understand this statement in its entirety. I have also read and understand the additional information provided to me by Inspiration. I hereby authorize hospice services to be provided to me by Inspiration.

I have been able to discuss the above conditions with a member of Inspiration staff and have had all my questions answered to my satisfaction.

\_\_\_\_\_  
**Signature of Patient or Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Representatives**

\_\_\_\_\_  
**Authority of Representative**

\_\_\_\_\_  
**If Patient Refuses/Is Unable to sign, Please Describe**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION & ACKNOWLEDGEMENT OF PRIVACY NOTICE.**

Patient Name: (Please Print)		DOB:	MRN:
Patient email:		Phone #:	SSN#:
Patient Address			
	City:	State:	Zip:

**Information to be Disclosed:** I authorize Inspiration-A Step Forward to **DISCLOSE** my patient information & location to:

*The Mortuary of Your Choice	*Clergy Listed on your Spiritual Assessment	*Nursing Facilities	*Pharmacies/Laborites
*Insurance Companies	*Hospitals/EMS	*Medical Equipment Vendors	*Social Service Agencies
*Your Referring Physician	*VA Services	*Transportation Companies	*State Appointed POA
<b>*Any Other Necessary Medical Agency</b>			

**I authorize the following person(s) to RECEIVE my patient information (IF YOU ARE NOT THE PATIENT PLEASE INCLUDE YOUR INFORMATION FIRST):**

Point of Contact's Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: <input type="checkbox"/>	Ongoing information about my care: <input type="checkbox"/>

Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: <input type="checkbox"/>	Ongoing information about my care: <input type="checkbox"/>

Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: <input type="checkbox"/>	Ongoing information about my care: <input type="checkbox"/>

\*I understand at the time of my death, the people listed above will be contacted by Inspiration-A Step Forward's Bereavement Team.

\*I understand that I may revoke this authorization in writing at any time.

\*I have received a copy of the Inspiration-A Step Forward's Notice of Privacy Practice which includes: identifying me as a patient at Inspiration-A Step Forward Hospice.

\*I have received a copy of the Inspiration-A Step Forward's Patient Right's and Responsibilities

\*Information relating to my care that may be shared is limited to: medication information, a summary of diagnosis and prognosis, and a list of services and personnel available for assistance.

**\*I understand that if I am the Medical Power of Attorney, I am required by Inspiration-A Step Forward to provide written documentation stating the patient's wishes.**

**I hereby authorize the use and/or disclosure of my personal information as indicated in the checked boxes above.**

Signature of Patient or Representative:		Date:
Printed Name of Patient or Representative:		Authority:
<b>If Patient Refuses/Is Unable to sign. Describe:</b>		
Witness Signature:	Printed Name of Witness:	Date:



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ MR#: \_\_\_\_\_

Address: \_\_\_\_\_  
Streets, City, State, Zip

I authorize the release of the following medical records to \_\_\_\_\_ from the below mentioned entities to be used for consultation, treatment, and billing purposes **(Check ALL That Apply)**:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Lab Results                  | <input type="checkbox"/> Discharge Summaries            |
| <input type="checkbox"/> Progress Notes                | <input type="checkbox"/> Psychology Evaluation        | <input type="checkbox"/> Nursing Notes                  |
| <input type="checkbox"/> Physician Orders              | <input type="checkbox"/> Social Work Assessment/Notes | <input type="checkbox"/> X-Ray Reports                  |
| <input type="checkbox"/> Aide Care Plans/Notes         | <input type="checkbox"/> Other Communicable Diseases  | <input type="checkbox"/> OT/PT Assessments/Notes        |
| <input type="checkbox"/> HIV Test Results              | <input type="checkbox"/> Consultation                 | <input type="checkbox"/> Alcohol/Drug History           |
| <input type="checkbox"/> AIDS/ARC Diagnosis/Treatments | <input type="checkbox"/> Other: _____                 | <input type="checkbox"/> <b>Complete Medical Record</b> |

\*If records pertain to mental health, substance abuse, AIDS/HIV, or spouse/child abuse, additional requirements may need to be met prior to release.

Exceptions to information released: \_\_\_\_\_

From:  Any Hospital/Outpatient Clinic that provided care to me during the previous 12 months (Please List):

\_\_\_\_\_

Any Doctor/Medical Office who has provided care in the previous 12 months (Please List):

\_\_\_\_\_

Any Nursing Home/Assisted Living Center that I resided in during the previous 12 months (Please List):

\_\_\_\_\_

The Referring Health Care Agency:

\_\_\_\_\_

\*The agencies listed above are released from all legal liability that may arise from the release of the information requested.

This authorization will remain effective for one year (1 year) unless an earlier date or event specified: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

You have the right to revoke this Authorization at any time, provided that you do so in writing directed to your health care provider's Privacy Contact, and except to the extent that he/she has already used or disclosed the information in reliance on this Authorization.

*I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that you have already used or disclosed the information in reliance on the Consent.*

A photocopy or facsimile of this authorization shall have the same force and effect as the original.

\*Should I refuse to sign this authorization, my ability to obtain care, payment, or enrollment in said health program will not be affected. I understand that I may revoke this authorization, in writing, at any time. Written revocation will be delivered to Inspiration-A Step Forward Hospice.

\*By signing this form, I authorize the release of records with the knowledge that Inspiration-A Step Forward Hospice may obtain information regarding any mental health, substance abuse, HIV/AIDS, or spousal/child abuse.

\_\_\_\_\_  
Signature of Patient/Guardian/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

If signed by a Personal Representative, please state the relationship: \_\_\_\_\_

**RE-DISCLOSURE BY THE RECIPIENT IS PROHIBITED. USE OF THIS INFORMATION FOR ANY PURPOSE OTHER THAN AS STATED ON THIS AUTHORIZATION IS PROHIBITED.**

## Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)\*

- Part I:** *Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.*
- Part II:** *Allows you to record your wishes about health care in writing.*
- Part III:** *Tells you how to revoke or change this directive.*
- Part IV:** *Makes your directive legal.*

### My Personal Information

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_\_

### Part I: My Agent (Health Care Power of Attorney)

#### A. No Agent

*If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.*

I do not want to choose an agent.

#### B. My Agent

Agent's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

#### C. My Alternate Agent

*This person will serve as your agent if your agent, named above, is unable or unwilling to serve.*

Alternate Agent's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

**Part I: My Agent (continued)**

**D. Agent's Authority**

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

**E. Other Authority**

My agent has the powers below only if I initial the "yes" option that precedes the statement. I authorize my agent to:

YES  NO Get copies of my medical records at any time, even when I can speak for myself.

YES  NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

**F. Limits/Expansion of Authority**

I wish to limit or expand the powers of my health care agent as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Nomination of Guardian**

*Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.*

YES  NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

**H. Consent to Participate in Medical Research**

YES  NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

**I. Organ Donation**

YES  NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

## Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

*Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

<b>Option 1</b>	
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	<b>I choose to let my agent decide.</b> I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.
Additional comments:	

<b>Option 2</b>	
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	<b>I choose to prolong life.</b> Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.
Additional comments:	

<b>Option 3</b>	
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	<b>I choose not to receive care for the purpose of prolonging life,</b> including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.
<i>If you choose this option, you must also choose either (a) or (b), below</i>	
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	(b) My health care provider should withhold or withdraw life-sustaining care if <b>at least one</b> of the initialed conditions is met:
<i>If you selected (a), above, do not choose any options under (b).</i>	<input type="checkbox"/> I have a progressive illness that will cause death
	<input type="checkbox"/> I am close to death and am unlikely to recover
	<input type="checkbox"/> I cannot communicate and it is unlikely that my condition will improve
	<input type="checkbox"/> I do not recognize my friends or family and it is unlikely that my condition will improve
	<input type="checkbox"/> I am in a persistent vegetative state
Additional comments:	

<b>Option 4</b>	
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> Initial	I do not wish to express preferences about health care wishes in this directive.
Additional comments	

Name: \_\_\_\_\_

## Part II: My Health Care Wishes (continued)

Additional instructions about your health care wishes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.*

## Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

- ◆ Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- ◆ Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- ◆ Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- ◆ Signing a new directive. *(If you sign more than one Advance Health Care Directive, the most recent one applies.)*

## Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

*If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.*

\_\_\_\_\_  
\_\_\_\_\_  
Name: \_\_\_\_\_

# Provider Order for Life-Sustaining Treatment (POLST) Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health  
State of Utah Rule R432-31 v3.1 February 2016 (<http://health.utah.gov/hflcra/forms.php>)

Patient's Last Name	First Name/Middle Initial	Effective Date of this Order
---------------------	---------------------------	------------------------------

Date of Birth	Last 4 of SS#	Address (street/city/state/zip)
---------------	---------------	---------------------------------

Medical Provider's Name (MD/DO/PA/APRN)	Medical Provider's Phone
---	--------------------------

Brief description of patient's medical condition

Patient's stated goals for medical care

**A. CARDIOPULMONARY RESUSCITATION (CPR)** Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
  Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
  I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

**B. MEDICAL INTERVENTIONS** Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

**FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.

**LIMITED ADDITIONAL INTERVENTIONS:** *Treating medical conditions while avoiding burdensome measures.* Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.

**COMFORT MEASURES:** *MAXIMIZING comfort and dignity.* Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.

**NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other Instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

**C. ARTIFICIAL NUTRITION**

Long term artificial nutrition with feeding tube
  Trial period of artificial nutrition with feeding tube
  No artificial nutrition
  I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

**D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES**

Advance Directive available, reviewed and confirmed without conflicts
  No Advance Directive available

Health care agent named in Advance Directive: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
  I, the patient, want this order to be followed strictly.

Discussed with: \_\_\_\_\_

**REQUIRED SIGNATURES**

Print Name: \_\_\_\_\_ Relationship: (write self if patient) \_\_\_\_\_ Signature: \_\_\_\_\_

Signature of Medical Provider (MD/DO/PA/APRN) <small>Two signatures required for minors</small>	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

U  
T  
A  
H  
  
P  
O  
L  
S  
T  
  
U  
T  
A  
H  
  
P  
O  
L  
S  
T  
  
U  
T  
A  
H  
  
P  
O  
L  
S  
T  
  
U  
T  
A  
H  
  
P  
O  
L  
S  
T

# Provider Order for Life-Sustaining Treatment (POLST)

## Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health  
State of Utah Rule R432-31 v3.1 February 2016 (<http://health.utah.gov/hfclra/forms.php>)

### DIRECTIONS FOR HEALTHCARE PROVIDERS

#### COMPLETING POLST

- This form is intended for both adult and pediatric patients.
- The POLST is not an Advance Directive and does not replace it. The POLST is a Medical Order.
- When available, review the Advance Directive and POLST form to ensure consistency.
- The POLST must be completed by a medical provider (MD/DO/PA/APRN) based on patient preferences and medical indications.
- The entire form should be completed. A patient may indicate that they "do not wish to express a preference" rather than leaving a section of the form blank.
- Section D, which indicates the degree of leeway the patient would like to grant their surrogate, must be completed by the individual patient and only if the patient has medical decision-making capacity.
- The POLST must be signed by the patient or surrogate decision maker AND by a medical provider (MD/DO/PA/APRN) to be valid. In the case of pediatric patients, signatures from two different medical providers are required.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid.

#### USING POLST

##### Section A:

- If a patient has selected "Do Not Attempt Resuscitation" and is **found pulse less and not breathing**, no defibrillator (including automated external defibrillators) or chest compressions should be used.

##### Section B:

- A person may chose "DNR" in Section A and "Full Treatment" in Section B, recognizing in Section A the setting refers to where there are no signs of life (palpable pulse) and Section B refers to the setting where there are signs of life.
- Choosing "Attempt to resuscitate" in Section A requires "Full treatment" in Section B as an attempt at resuscitation may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, and/or vasopressors.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures," may be transferred to the hospital to provide comfort (e.g., treatment of hip fracture).
- If a patient has indicated that he/she would not want to return to the hospital, this should be written in the "other instructions and clarifications" section of the form.
- IV antibiotics and fluids are generally not considered "Comfort Measures" and may prolong life. A person who desires IV fluids or IV antibiotics should indicate "Limited Additional Interventions" or "Full Treatment."
- Some IV medications (e.g. medication for pain, nausea, delirium, etc.) may be appropriate for a patient who has chosen "Comfort Measures."

#### REVIEWING POLST

This form should be reviewed periodically (consider at least annually). Review is also recommended when:

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

#### MODIFYING AND VOIDING POLST

- The POLST form can be modified at any time if a patient changes his/her mind about his/her treatment preferences by completing a new POLST form.
- If a patient has given sufficient leeway to his/her surrogate to modify the POLST form, any modifications made should be consistent with patient preferences and in collaboration with the medical provider.
- It is recommended that revocation of the form be documented by drawing a line through sections A through D, writing "VOID" in large letters, and signing/dating the form.
- The most recently dated POLST is considered the valid POLST. The most recently dated POLST orders supersede all prior POLST directives.

*Place this form in a prominently visible part of the patient's record or home. A copy of this form must accompany the patient when transferred or discharged (including transfers to hospital emergency departments).*

U  
T  
A  
H  
  
P  
O  
L  
S  
T  
  
U  
T  
A  
H  
  
P  
O  
L  
S  
T  
  
U  
T  
A  
H  
  
P  
O  
L  
S  
T