Fax

To: OR POLST REGISTRY: 503-418-2161

Organization Name:

Contact Name:

Fax: Phone:

Date: Pages:

REMINDER: REQUIRED ELEMENTS FOR POLST FORM TO BE ENTERED INTO REGISTRY**.**

- ☐ Patient's full name
- ☐ Patient's date of birth
- ☐ At least one order section must be completed*
- ☐ Date form signed
- ☐ Signature** of Physician, NP, PA, or ND

**The Registry cannot accept POLST forms marked "Resuscitate" (Section A) and "Comfort Measures Only" (Section B). These orders cannot be interpreted by EMS.*
***"Signed" means a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030.*

POLST Registry ID Report (OPTIONAL)

Please complete the following information to receive the POLST Registry ID number(s) assigned to the patient/resident orders within this fax. The primary contact person listed below certifies the authority to make this request and the security of the listed fax number to receive protected health information.

Facility/Institution Name: _____

Primary Contact Person: _____

Secure Fax number: _____ **Phone number:** _____ **x**_____

Patient Name	**Patient DOB**	*POLST Registry ID*	*Date Signed*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			