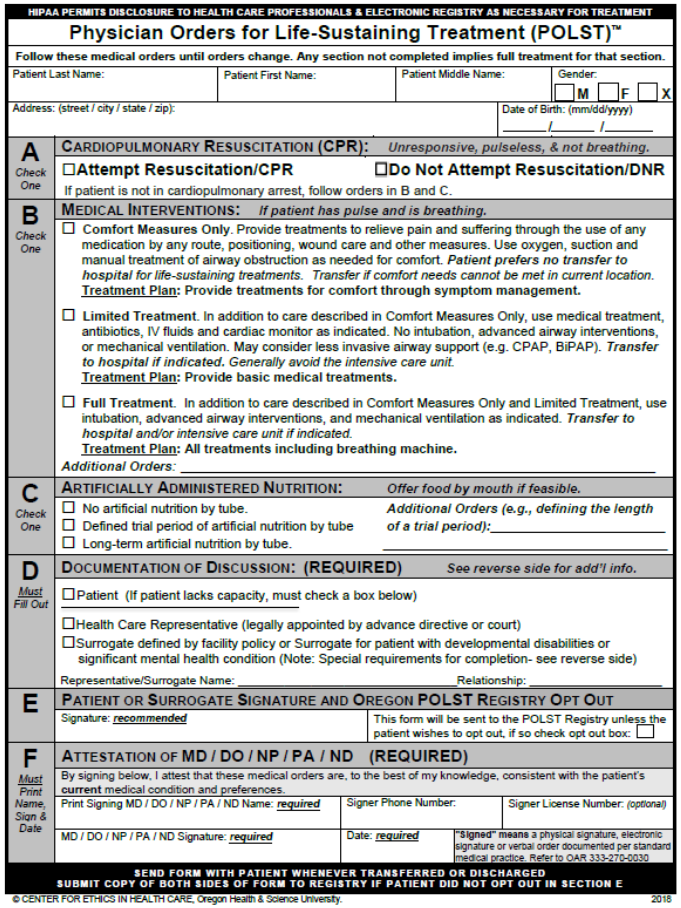
The Oregon POLST Registry

For HIM Departments & Clinic Support Staff

POR®
physician orders for life-sustaining treatment paradigm®
Oregon POLST Registry

What is the Oregon POLST Registry?

- It is a secure electronic database of POLST orders.
- The Registry allows emergency medical professionals treating a patient access to POLST orders *if* the original POLST form cannot be immediately located.
- Non-urgent access is available for those involved in patient care.



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)™

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name: | Patient First Name: | Patient Middle Name: | Gender: ☐M ☐F ☐X

Address: (street / city / state / zip): | Date of Birth: (mm/dd/yyyy) ____/____/____

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

☐**Attempt Resuscitation/CPR** ☐**Do Not Attempt Resuscitation/DNR**

If patient is not in cardiopulmonary arrest, follow orders in B and C.

B Check One — **MEDICAL INTERVENTIONS:** *If patient has pulse and is breathing.*

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible.*

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube
☐ Long-term artificial nutrition by tube.

Additional Orders (e.g., defining the length of a trial period): _____

D Must Fill Out — **DOCUMENTATION OF DISCUSSION: (REQUIRED)** *See reverse side for add'l info.*

☐Patient (If patient lacks capacity, must check a box below)

☐Health Care Representative (legally appointed by advance directive or court)
☐Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion- see reverse side)

Representative/Surrogate Name: _____ Relationship: _____

E — **PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT**

Signature: ***recommended*** | This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box: ☐

F Must Print Name, Sign & Date — **ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)**

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: ***required*** | Signer Phone Number: | Signer License Number: *(optional)*

MD / DO / NP / PA / ND Signature: ***required*** | Date: ***required*** | **"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

 2018

Required Form Submission

- Oregon POLST forms signed on or after Dec 3, 2009 are **required** to be submitted by the form signer (or their designee).
- Oregon POLST forms signed prior to Dec 3, 2009 can be voluntarily submitted if the patient address is included.
- Patients may opt-out of the Registry at any time

Submitting Forms to the Registry

- What information is required for an Oregon POLST form to be entered into the Registry?
  - The patient's full name
  - The patient's date of birth
  - A legible physician/NP/PA/ND signature*
  - Date signed
  - At least one order section must be completed for entry into the Registry**

* "Signed" means a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

**The Registry cannot accept POLST forms marked "Resuscitate" (Section A) and "Comfort Measures Only" (Section B). These orders cannot be interpreted by EMS. Additional information can be found in the Oregon POLST Program's, Guidance for Oregon's Health Care Professionals.

Submitting Forms to the Registry

- Fax or mail copies of POLST forms (front and back) to the Registry business office along with a coversheet from your institution.
  - **Fax: 503-418-2161**
  - **Mail:** 3181 SW Sam Jackson Park Rd*
    Mail Code BTE 234
    Portland, OR 97239

  **If you are mailing forms, please do not use staples*
- **Why include a fax coversheet?** Without a coversheet, your organization cannot be "credited" for the submission, and follow-up with questions cannot occur.

Optional Demographic Information

- Optional demographics* include:
  - Gender
  - Address
  - Last 4 digits of social security number (on forms prior to 2018)

- Providing optional demographics is **highly** recommended.
  - This information helps expedite patient identification.
  - Address information allows the Registry to send a confirmation packet to the patient.

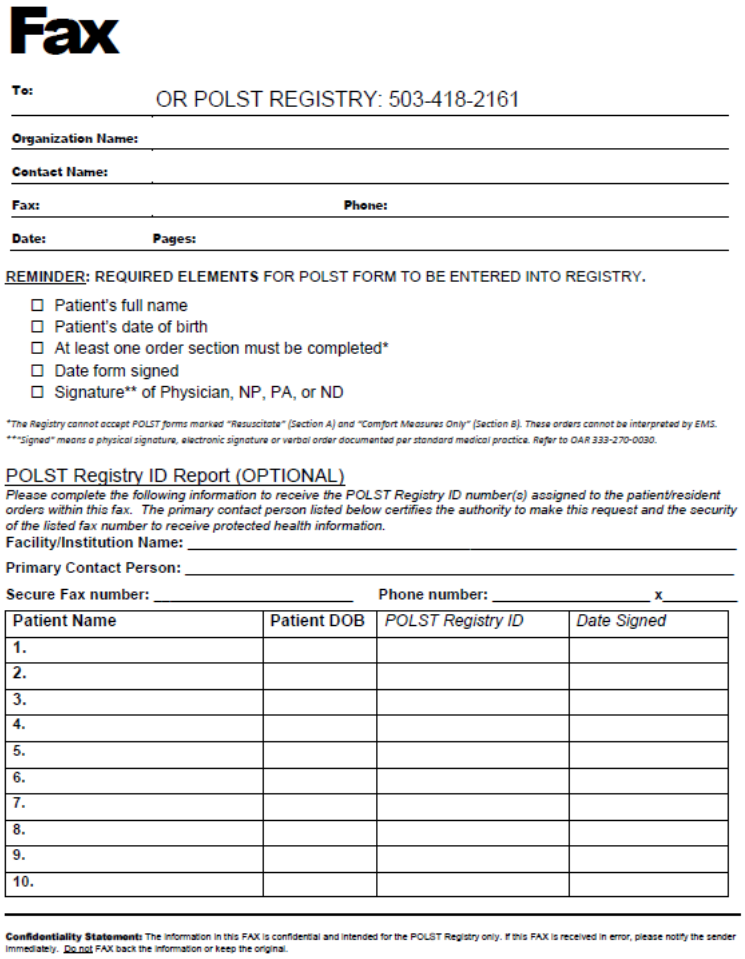
**If optional information is illegible clarification will be requested*

Registry ID Request Coversheets

Registry ID is the patient's unique ID in the Registry system

- Coversheet can be obtained on our website.
- Allows for your office to receive patients' Registry IDs
- Alerts you if the Registry has a *newer** POLST form than you have on file.

**Reminder: only the newest POLST form signed is valid for use*.



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

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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.			

Confidentiality Statement: The information in this FAX is confidential and intended for the POLST Registry only. If this FAX is received in error, please notify the sender immediately. Do not FAX back the information or keep the original.

Example Submission Process

Collect

- Collect all POLST forms signed that day/week. Please do not send large "batches" of files collected over longer periods as it delays entry and POLST form availability.
- Compile optional demographics sheets if applicable.

Verify

- Verify that all required elements are present.
- Clarify (on the form) any information that may be hard to read.

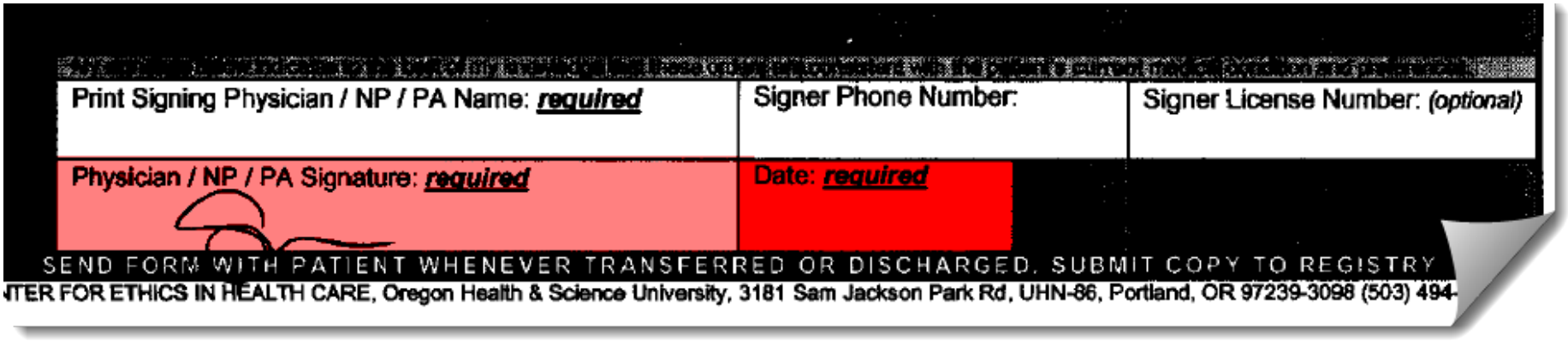
Submit

- Fax or mail to OPR with a coversheet identifying your institution.*
  - **Fax**: 503-418-2161
  - **Mail**: 3181 SW Sam Jackson Park Rd, Mail Code: BTE234, Portland, OR 97239

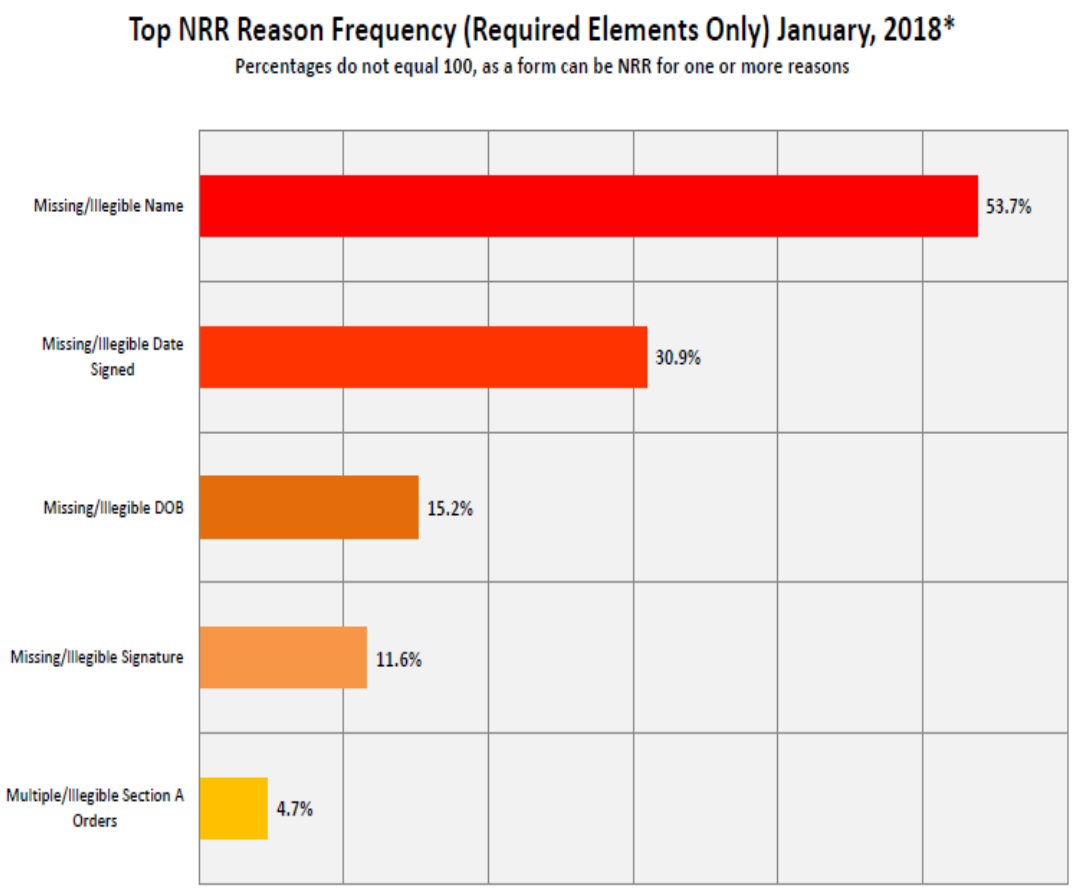
  *If you would like a returned list of Registry IDs, include a Registry ID request form.

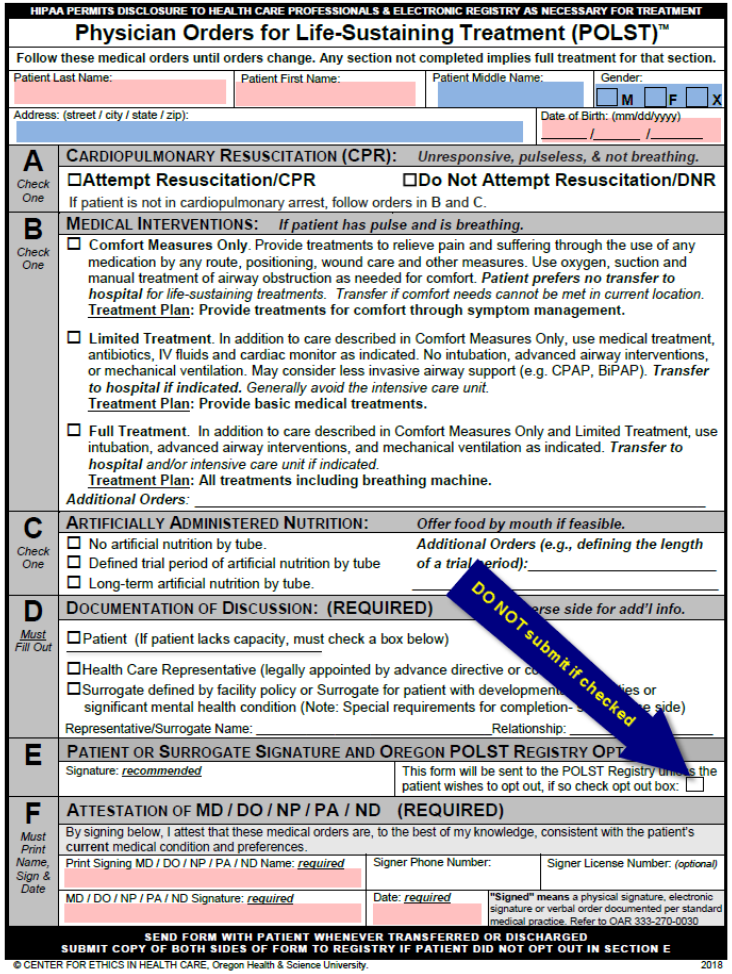
Why are forms being faxed back?

- Forms that have **missing or illegible** information, preventing them from being entered in the Registry, are faxed back for clarification.
- These forms are considered Not Registry Ready, or *NRR*
  - *Below is an example portion of a form with an illegible signature and missing date*



Most Common Reasons a Form is Sent Back

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☐Surrogate defined by facility policy or Surrogate for patient with developmen... ...ies or significant mental health condition (Note: Special requirements for completion- ...e side)

Representative/Surrogate Name: _____ Relationship: _____

DO NOT submit if checked

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SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION E

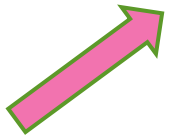
Resolving NRR Issues

Clarify

- Clarify the requested information when possible.

Resubmit

- Fax form back to the Registry.
- Include the NRR reference number.



Facsimile

PR
physician orders for life-sustaining treatment paradigm®
Oregon POLST Registry

Oregon POLST Registry
3181 SW Sam Jackson Park Rd
BTE234
Portland, OR 97239-3098
Ph. 503-418-4083
Toll free. 877-367-7657
Fax. 503-418-2161
www.orpolstregistry.org
polstreg@ohsu.edu

Deliver to: Example Clinic

Fax:

Date: Total pages (including cover):

From:

Thank you for contacting the Oregon POLST Registry.

We were **UNABLE** to enter the following form into the Registry because:

NRR REF#00001

Form is not signed

We request that clarifications/corrections be made on the form itself. When faxing back, please include this coversheet and/or the NRR reference number. If you have any questions regarding the issue(s) on this form, please call 877-367-7657.

Thank you,

The Oregon POLST Registry Team

The 3 times you should notify the Registry:

- A form is updated or a new form is received
- A POLST form is revoked or voided
- A patient is known to be deceased

What happens after submission?

Entry

- Registry ready forms are entered into Registry.

Confirmation

- A confirmation packet is mailed to the Registrant.
- Packet includes a Registry ID magnet and set of stickers.

Utilization

- Emergency health care professionals call the Registry Hotline *if* a POLST form cannot be immediately found.
- Clinics and support staff call the Registry Business office with non-urgent POLST form requests.

Non-urgent POLST Form Requests

- Non-urgent access to a patient's POLST form is available for health care professionals via fax.
  - **POLST orders <u>cannot</u> be relayed over the phone.**

- Obtaining a copy of a registered POLST is easy!
  - Call the Registry business office at 877-367-7657.
  - Fax documentation* confirming the patient is in your care.
  - Forms on file will be faxed to your office within **1** business day.

**Forms cannot be released until documentation is received*

Non-Urgent Access: Bulk Form Requests

- Bulk requests are requests for more than 20 forms.
- Requests of this size can take up to 4 weeks to complete.
- May require patient identifiers to be submitted electronically.
- Call the Registry Business office **first** to set up this type of request at *1-877-367-7657*

We're here to help!

- Contact the Registry business office for all non-urgent questions
  - Phone: 503-418-4083
  - Toll free: 877-367-7657
  - Fax: 503-418-2161
  - E-mail: polstreg@ohsu.edu
  - Website: www.orpolstregistry.org