FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP/POLST)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates default treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

Last Name:	First Name, MI:	
Date of Birth:	Last 4 SSN or Patient ID#:	

A. CHECK ONE

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

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

☐ **Do Not Attempt Resuscitation**
(DNAR/no CPR/Allow Natural Death)

B. CHECK ONE

INITIAL TREATMENT ORDERS: Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss treatments with patient and/or representative regularly to ensure patients care goals are met.

☐ **Full Treatments (required if CPR chosen in Section A).** **GOAL: Attempt to sustain life by all medically effective means.** Provide appropriate medical treatments as indicated in an attempt to prolong life, including intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion, including intensive care.

☐ **Selective Treatments.** **GOAL: Attempt to restore functions while avoiding intensive care and resuscitation efforts (i.e., ventilator, defibrillation, and cardioversion).** May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** **GOAL: Attempt to maximize comfort through symptom management only; allow natural death.** Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or selective treatments unless consistent with comfort goal. Transfer to hospital if comfort cannot be achieved in current setting.

C. CHECK ONE

MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if desired by patient, is safe and tolerated.

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for medically assisted nutrition but no surgically-placed tubes
☐ No medically assisted means of nutrition desired
☐ Not discussed or no decision made

D.

ADDITIONAL ORDERS OR INSTRUCTIONS FOR SECTIONS B AND C: Includes e.g., time trials, blood products, and other orders. [EMS Protocols may limit emergency responder ability to act on orders in this section.]

E. CHECK ALL THAT APPLY

INFORMATION AND SIGNATURES (E-Signed documents are valid)

Discussed with:

☐ Patient ☐ Agent/DPOA Health Care ☐ Parent of minor ☐ Legal guardian
☐ Patient Representative ☐ Other *(specify)*: _____

Signature of patient or recognized decision maker (all fields required): By signing this form, the patient/recognized decision maker voluntarily acknowledges that this treatment order is consistent with the known desires and/or best interest of the patient.

Print name:	Signature:	The most recently completed valid TPOPP/POLST form supersedes all previously completed TPOPP/POLST forms.
Address:	Relationship:	Phone:

Signature of authorized healthcare provider (all fields required): My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences. (verbal orders are acceptable with follow up signature)

Print name of authorized provider and/or Physician:	Phone:
Signature of authorized provider:	Date:

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

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Patient Last Name:	First Name, MI:	DOB:	Last 4 SSN/Patient ID#:

ADVANCE CARE DIRECTIVES & EMERGENCY CONTACTS

Review of Advance Directives (Check all that apply)

☐ Healthcare Directive (Living Will) ☐ Other Instructions or Documents

☐ Advance Directives Unavailable ☐ No Advance Directives Exist

☐ Appointment of Durable Power of Attorney for Health Care (Name):_____ (Phone):_____

Patient's Emergency Contact (if other than person signing form) and Provider(s)

Full Name:_____ Phone (voice __ text __): _____

Primary Care Provider Name: _____ Phone: _____

Hospice Care Agency (If Applicable) Name: _____ Phone: _____

Health Care Providers and Others Assisting with Form Preparation Process (Check all that apply)

☐ Social Worker ☐ Nurse ☐ Clergy ☐ Palliative Care Provider

☐ Health Care Agent ☐ Parent of Minor ☐ Family Member ☐ "Person of Care and Concern"

☐ Patient Advocate ☐ Legal Guardian ☐ Other: _____

Instructions for Completing TPOPP/POLST

- Completing a TPOPP/POLST form is always voluntary. TPOPP/POLST is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- TPOPP/POLST is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- TPOPP/POLST must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA in compliance with state law, regulation, and scope of practice; and by patient *(or representative)* to be valid.
- Photocopies and Faxes of signed TPOPP/POLST forms are valid. Use of original form is strongly encouraged. A copy shall be retained in patient's medical record and accompany the patient to all settings.

Using TPOPP/POLST

(Any incomplete section of TPOPP/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 person if "Do Not Attempt Resuscitation" is selected.
- **SECTION B:**
  - When comfort cannot be achieved in the current setting, the person, including someone with "Comfort-focused Treatments" 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.

Reviewing TPOPP/POLST

- TPOPP/POLST form should be reviewed when:
  - The person is transferred from one care setting or care level to another, or
  - There is a substantial change in the person's health status, or
  - The person's treatment preferences change, or
  - The care provider changes.

Modifying and Voiding TPOPP/POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a TPOPP/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.
- A legally recognized decision-maker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

For information, clinical guidance resources or to obtain more forms, contact: TPOPP@practicalbioethics.org

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