1180 N. INDIAN CANYON, E420
PALM SPRINGS, CA 92262

DR. AGARWAL

7281 DUMOSA AVE, STE 2
YUCCA VALLEY, CA 92284

Patient Information

PLEASE COMPLETE ALL THE INFORMATION REQUESTED

Date:____________________

Title: ◯ Mrs. ◯ Ms. ◯ Mr. ◯ Dr. Date of Birth: ___________________________ Sex: ◯ M ◯ F

Name: ____

Street: ____City: _________________________________

State: _______________________Zip: ____________________Social Security #:___________________________

Home: _________________________Cell: ________________________Work: _____________________Ext: ___

Marital Status: M S W D Driver's License/ID:____

Primary Language:________________________________Race/Ethnicity:________________________________

Pharmacy Name: __________________________________Email:_______________________________________

Emergency Contact: _____________________________________Phone Number:__________________________

Relationship to Patient:____

Insurance Information

Primary Insurance:__________________________________Insured Name:_____________________________

Member ID:___________________________________Group:________________________Plan Code:_________

Relationship to Patient:________________________________ _Subscriber DOB:__________________________

Secondary Insurance:_________________________________Insured Name: ____________________________

Member ID:________________________Group:________________________________Plan Code:____________

Relationship to Patient:______________________________Subscriber DOB:_____________________________

Signature:____Date:_____________________________

Please Check one: ◯ Patient ◯ Authorized Representative ◯ Parent or Guardian of Minor

PATIENT HISTORY FORM

Patient's Name:_________________________Date of Birth:__________________Today's Date:___________

Past Medical History

Previous Physician's Name:____________________ Date of last exam:____________________________

Have you ever been hospitalized? ◯ Yes ◯ No If yes, what for?_________________________________

Have you ever been tested for hepatitis A, B, or C? ◯ Yes ◯ No Which Hepatitis virus?___________________________

Have you been vaccinated for Hepatitis B? ◯ Yes ◯ No If yes, date vaccine series completed:________________

Have you been vaccinated for Hepatitis A? ◯ Yes ◯ No If yes, date vaccine series completed:________________

Last Tuberculosis(TB) screening?____________________ Result of chest X-ray: ◯Positive ◯Negative

If positive TB screen, date of last chest x-ray:_____________ Result of TB Screening: ◯Positive ◯Negative

Have you had a sexually transmitted disease? ◯ Yes ◯ No Diagnosis:_____________________________________

Which of the following conditions are you currently being treated or have been treated for in the past(PLEASE CHECK):

◯Heart disease/murmur/angina ◯Sinus problems ◯Depression/Anxiety
◯High cholesterol ◯Seasonal allergies ◯Psychiatric care
◯High blood pressure ◯Tonsillitis ◯Diabetes
◯Low blood pressure ◯Ear problems ◯Kidney/bladder problems
◯Heartburn (reflux) ◯Eye disorder/glaucoma ◯Liver problems/hepatitis
◯Anemia or blood problems ◯Seizures ◯Arthritis
◯Swollen ankles ◯Stroke ◯Cancer
◯Shortness of breath ◯Headaches/Migraines ◯Ulcers/colitis
◯Asthma ◯Neurological problems ◯Thyroid problems
◯Lung problems/cough

Please describe any current or past medical treatment not listed above:

____

____

Please list your past surgeries:

____

____

Allergies

Are you allergic to penicillin or any other drugs? ◯ Yes ◯ No Other:____________________________

Please List all Medications you take:

____

____

PATIENT HISTORY FORM

Social and Preventive History

Do you currently smoke or chew tobacco? ◯ Yes ◯ No   If no, have you in the past? ◯ Yes ◯ No

Do you drink alcohol, beer, or wine? ◯ Yes ◯ No   If no, have you in the past? ◯ Yes ◯ No
How many drinks per week?__________________

Do you currently drink coffee and/or tea? ◯ Yes ◯ No   If yes, how many cups per day?__________________

Do you exercise daily/weekly? ◯Yes ◯No

Family History

	Living	Age(or age at death)	List serious illnesses
Mother	◯YES ◯NO		
Father	◯YES ◯NO		
Sisters	◯YES ◯NO		
	◯YES ◯NO		
	◯YES ◯NO		
Brothers	◯YES ◯NO		
	◯YES ◯NO		
	◯YES ◯NO		
	◯YES ◯NO		

Has any member of your family(including children and parents) had any of the following illnesses:

Illness	Which family member?	Illness	Which Family Member?
Anemia or blood disease		High Blood Pressure	
Cancer		HIV Disease/AIDS	
Diabetes		Mental Illness/Depression	
Glaucoma		Stroke	
Heart Disease		Other serious illness	

Females: Gynecological History

How many times have you been pregnant?______________   Date of last Pap Smear:__________________
Have you had an abnormal Pap Smear? ◯YES ◯NO   Diagnosis:____________ Follow-Up:__________
Date of last mammogram:______________________   Mammogram results:__________________
Have you ever had a breast biopsy? ◯YES ◯NO __________   Biopsy result:__________________

By signing today, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

______________________________   ______________________

Patient/Legal Guardian Signature   Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

____

DATE OF BIRTH

____

PRINT PATIENT NAME

____

PATIENT SIGNATURE

____

DATE

1180 N. INDIAN CANYON, E420 **DR. AGARWAL** 7281 DUMOSA AVE, STE 2
PALM SPRINGS, CA 92262 YUCCA VALLEY, CA 92284
Phone: (760) 778 7147 Fax: (760) 699 8675

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name : _________________________Date of Birth: ___________Social Security: _________________

I request and authorize ___________________________ to release healthcare information of the patient named above to:

Name: ____

Address: ____

Phone: __________________________ Fax: ________________________

City: ____ State: _________ Zip Code: __________

This request and authorization applies to;

□ Healthcare information relating to the following treatment, condition, or dates:

____

□ All Healthcare information for the last 2 years □ Lab Results □ X-Rays & Radiology Reports □ Medication List

□ Information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral/mental health services.

□ Other: ____

This authorization will remain in effect:

* From the date of this authorization until: ____

* Until the following event occurs: ____

Unless otherwise noted above this authorization will remain in effect 90 day from the date signed.

_____________________________________ _____________________________________

Signature of Patient or Legal Representative Date

____

Print Name

MYMD247

INSURANCE WAIVER

AND

DME/SERVICE WAIVER

_______________________________ _______________________________

DATE DATE OF BIRTH

I, ____, understand that if I am not eligible with the insurance named above or my insurance has changed or terminated, I or the person financially responsible for me will assume full responsibly for all charges incurred myself.

IF HMO: I AM AWARE THAT MY HMO REQUIRES ME TO BE ASSIGNED TO THIS OFFICE/DOCTOR AND IF I AM NO ASSIGNED TO THIS OFFICE/DOCTOR, I WILL BE OR THE PERSON FINACIALLY RESPONSIBLE FOR ME WILL ASSUME FULL RESPONSIBILTY FOR ALL CHARGES INCURRED BY MYSELF.

I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges. I also understand that any co-pay that applies to such visit with be billed to me within 30 days, and that I am responsible for paying such co-pay.

_______________________________ _______________________________

Patient's Signature Date

ADVANCED DIRECTIVE NOTIFICATION

I, THE UNDERSIGNED, HAVE RECEIVED INFORMATION REGARDING ADVANCED DIRECTIVES.

I UNDERSTAND, SHOULD I HAVE ANY QUESTIONS, THAT I MAY DISCUSS ADVANCED DIRECTIVE ISSUES WITH MY PHYSICIAN.

____

PATIENT SIGNATURE

____

DATE

Dimple Agarwal, MD

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.

PLEASE REVIEW CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information with you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

LAW REQUIRES US TO:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

WE HAVE THE RIGHT TO:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

1. Before we make an important change in our privacy practices, we will change this notice and make a new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. <u>We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.</u>

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating your.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluation the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, and health care operations, we may use and disclose medical information for the following purposes.

NOTIFICATION: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

DISASTER RELIEF: Medical information with a public or private organization or person who can leagally assist in disaster relief efforts.

RESEARCH LIMITED CIRCUMSTANCES: Medical information for research purposes in limited circumstances were the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

FUNERAL DIRECTOR, CORONER, MEDICAL EXAMINER: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

SPECIALIZED GOVERNMENT FUNCTIONS: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determination for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

COUR ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information, with a law enforcement officials. We may share limited information, with a law enforcement official concerning the medical information of a inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to tract products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition. \

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your medical information, if necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification

and location at the request of a law enforcement official, reports, regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

3. YOUR INDIVIDUAL RIGHTS

YOU HAVE A RIGHT TO:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge depending on how many pages your chart is, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not creat the information you wanted changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESITONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ADVANCE DIRECTIVES

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written document that describes an individual's choice about how health care decisions should be made in the future if the individual is unable to provide that information. Examples of advance directives include durable power of attorney for health care and living wills. They often address end-of-life issues. The federal Patient Self Determination Act requires most facilities/homes to provide information to residents about advance directives. The Act also gives each resident the right to choose whether or not to make an advance directive.

WHO HAS TO PROVIDE INFORMATION TO A RESIDENT ABOUT ADVANCE DIRECTIVES?

The federal Patient Self Determination Act requires all health care providers who participate in the Medicare or Medicaid program to provide information to residents about advance directives, and to give them an opportunity to execute advance directives if they choose to do so.

WHEN SHOULD BE DONE BEFORE IMPLEMENTING AN ADVANCE DIRECTIVE?

Even when the resident's current medical event is addressed by the resident's advance directive, the provider and staff must first inform the resident or the resident's legal decision maker about possible treatment before implementation of the advance directive.

WHAT SHOULD I DO IN AN EMERGENCY IF I CANNOT OBTAIN AN INFORMED CONSENT DECISION?

RCW 7.70.050 allows a provider to implement an advance directive in good faith if, in an emergency, the provider cannot obtain an informed consent decision due to the incompetence of the resident or the unavailability of the legal decision maker. Because some assessment and decisions about end-of-life issues may only be made by a licensed practitioner, please contact your attorney for more specific information, including any questions about scope of practice issues.

IS THERE A SPECIFIC FORM REQUIRED FOR ADVANCE DIRECTIVES?

No. A specific form is not required for advance directives. There are forms available that you may access and use but no specific form is required.

WHAT ARE MY RESPONSIBILITIES AS A LONG TERM CARE FACILITY/HOME ON HEALTH CARE DECISION MAKING ISSUES?

All long-term care facilities/homes must have operational policies and procedures directing staff how to handle a resident's medical emergency, including informed consent and implementation of advance directives. This also includes the use of the POLST form if the resident has one.

ARE THERE ANY SPECIFIC ASSESSMENT RELATED ISSUES THAT I NEED TO CONSIDER?

All long-term care facilities/homes must assess resident's cognitive capacity and identify whether the resident or someone else has the authority to make health care decisions for the individual. Part of this process would involve 1) determining whether the resident has executed an advance directive, and if the advance directive is in effect, and 2) if the resident will not be making his or her own decisions, identifying the appropriate surrogate decision maker. This information should be documented in the resident's record.

SHOULD ADVANCE DIRECTIVES AND ANY POLST FORM BE ACCESSIBLE?

Yes. Both should be kept in a place easily accessible by anyone who has the right to or need for that information. The Washington State Medical Association recommends the POLST form being the first document in the resident's record. If this type of document is kept in the same place for each resident, then staff or anyone else who has the

right to the information will be able to quickly access the information. For example, the facility/home might decide that residents' POLST form will be the top document in each resident's file.

CAN I BE A POWER OF ATTORNEY FOR A RESIDENT?

Owners, operators, administrators and employees of a long term care facility/home where a resident resides cannot act as power of attorney for the resident unless they are also the spouse, adult child or brother or sister of the resident. (RCW 11.94.010)

INFORMED CONSENT

WHAT IS INFORMED CONSENT AND WHO MUST BE GIVEN INFORMED CONSENT?

The law (chapter 7.70 RCW) provides everyone with the right to be fully informed of health care issues that have the potential to affect their lives. As part of the informed consent process, the health care provider must tell individuals about the risks and benefits of certain actions or treatments, and about the risk of not having treatment. Actions or treatments that inquire informed consent include decisions about what medication to take, whether to change medical treatment, or how to handle life threatening problems. Except in an emergency, informed consent must be given before a health care decision is made, whether or not the person has an advance directive.

WHO IS AUTHORIZED TO PROVIDE THE INFORMATION A PERSON NEEDS IN ORDER TO MAKE AN INFORMED DECISION?

Usually the information should be provided by the practitioner who orders the medication or treatment in question. RCW 7.70.020 gives health care providers the authority to give the information. Health care providers are defined as persons, including physicians and nurses, licensed by this state to provide health care or related services. If the health care provider's license gives him/her the scope of practice to provide informed consent information, then he or she may do so.

WHO IS AUTHORIZED TO MAKE AN INFORMED CONSENT DECISION FOR HEALTH CARE WHEN A RESIDENT IS NOT COMPETENT?

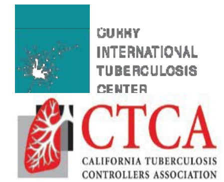
The state law regarding informed consent (RCW 7.70.065) lists, in the order of priority, the persons authorized to provide informed consent for health care on behalf of individuals who are not competent to consent themselves. Long term care facilities and other health care providers are required to use this list to determine the appropriate surrogate decision maker.

- The appointed guardian of the patient, if any;
- The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions (DPOAHC);
- The patient's spouse;
- Children of the patient who are at least eighteen years of age;
- Parents of the patient; and
- Adult brothers and sisters of the patient.

MAY NIECES OR NEPHEWS MAKE INFORMED CONSENT DECISIONS FOR AN INDIVIDUAL?

Since nieces and nephews are not on the list of surrogate decisions makers, they may only make informed consent decisions if they have been appointed guardian for the individual, or if the individual has designated them as durable power of attorney for health care decisions.

California Adult Tuberculosis Risk Assessment



- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned
HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: Dimple Agarwal, MD	Patient Name: ______________
Assessment Date: ______________	Date of Birth: ______________

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

Name :
Date :

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __*0*__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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

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

Physician Orders for Life-Sustaining Treatment (POLST)

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 — Check One

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.***

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **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 — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

- ☐ 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 #: 7607787147	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