Orcas Island Fire & Rescue

Neighbors Serving Neighbors Since 1948

When seconds count...

In the event of a medical emergency, information is vital. There may be no time to search for critical paperwork or information. What if you are not able to communicate with emergency responders?

The **L**ifesaving **I**nformation **F**or **E**mergencies (**LIFE**) Medical Form is a simple way to provide answers to questions when it is needed most. Complete the **L I F E** form, insert it in the provided EMS envelope and keep the envelope in a highly visible location. We suggest the front of your refrigerator. Emergency responders will recognize the packet and use the information inside.

You may also want to provide other medical forms such as the P.O.L.S.T. directive. (**P**hysician **O**rders for **L**ife **S**ustaining **T**reatment) Advanced packet is enclosed. More are available upon request.

We ask that you keep your information current. If you have new medications or a different doctor, responders need to know. Additional forms are available at the Eastsound Fire Station.

For more information about this form and other services provided, please call Orcas Island Fire and Rescue at (360) 376-2331 or visit our website www.orcasfire.org

San Juan County Fire Protection District #2
45 Lavender Lane, Eastsound, WA 98245

Orcas Island Fire & Rescue
2014 L.I.F.E. Medical Forms
(Lifesaving Information For Emergencies)

Patient Information

Name _____ Date of Birth _____
Address _____ Age _____ ☐ Male ☐ Female
City _____ Zip _____
Primary Phone _____

Primary Physician's Name _____
Physician's Phone _____
Hospital Peference _____

Have you been a patient there before? ☐ Yes ☐ No
Do you have Airlift / Island Air Membership? ☐ Yes ☐ No
Do you have Health Insurance? ☐ Yes ☐ No
Do you have a Medical Directive? ☐ No ☐ Yes
☐ P.O.L.S.T. ☐ Other
Where can we find it? _____

Heath Information *Current Medications - Please list on back of this form*

Allergies to any medications? ☐ No ☐ Yes _____
Other allergies ☐ None _____

Do you have a pacemaker? ☐ No ☐ Yes Brand & Model # _____

Previous Medical Problems *(Check all that apply)*

☐ Stroke / TIA ☐ Anemia ☐ Asthma ☐ Cancer *(location)* _____
☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Glaucoma
☐ Heart ☐ Blood Issue ☐ Liver Issue ☐ HIV / AIDS
☐ High Blood Pressure ☐ Low Blood Pressure
☐ Cardiac Stent ☐ Other _____

Previous Surgeries ☐ None

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

Emergency Contacts

Name _____ Phone _____
Address _____
_____ Relationship _____

Name _____ Phone _____
Address _____
_____ Relationship _____

Baseline Vital Signs

Date:						
B/P	/	/	/	/	/	/
HR						
Pulse						
Height						
Weight						
Temp.						

Prescribed Mediations

Medication _____ Dose _____ Times Per Day _____
General Reaso _____

Medication _____ Dose _____ Times Per Day _____
General Reaso _____

Medication _____ Dose _____ Times Per Day _____
General Reaso _____

Medication _____ Dose _____ Times Per Day _____
General Reaso _____

Medication _____ Dose _____ Times Per Day _____
General Reason _____

Medication _____ Dose _____ Times Per Day _____
General Reason _____

Medication _____ Dose _____ Times Per Day _____
General Reason _____

Medication _____ Dose _____ Times Per Day _____
General Reason _____

Medication _____ Dose _____ Times Per Day _____
General Reason _____

Over the Counter Medications, Vitamins or Suppliments

Name _____
General Reason _____

Name _____
General Reason _____

Name _____
General Reason _____

Other Comments

_____
_____
_____
_____
_____
_____
_____

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

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ___ ___ ___ | Last 4 #SSN ___ ___ ___ ___ | Gender M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

Check One

☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Medical Interventions: Person has pulse and/or is breathing.

Check One

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

C Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Health Care Agent (DPOAHC) ☐ Spouse/Other:	PRINT — Physician/ARNP/PA-C Name	Phone Number
	X Physician/ARNP/PA-C Signature ***(mandatory)***	Date
PRINT — Patient or Legal Surrogate Name		Phone Number
	X Patient or Legal Surrogate Signature ***(mandatory)***	Date

Person has: ☐ Health Care Directive (living will) ☐ Living Will Registry ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 2/2011

Photocopies and FAXes of signed POLST forms are legal and valid. May make copies for records

Washington State Medical Association WSMA — Physician Driven Patient Focused

Washington State Department of Health

OVER ▶

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

Other Contact Information (Optional)

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

D ADDITIONAL PATIENT PREFERENCES (OPTIONAL)

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ No medically assisted nutrition by tube. ☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, etc. Attach additional orders if necessary.)

✗ Physician/ARNP/PA-C Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- Must be completed by health care professional.
- Should reflect person's current preferences and medical indications. Encourage completion of an advance directive.
- POLST must be signed by a physician/ARNP/PA-C to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is effective across all settings including hospitals until replaced by new physicians's orders.

The health care professional should inquire about other advance directives. In the event of a conflict, the most recently completed form takes precedence.

SECTION A:
- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:
- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

A person with capacity or the surrogate of a person without capacity, can void the form and request alternative treatment.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

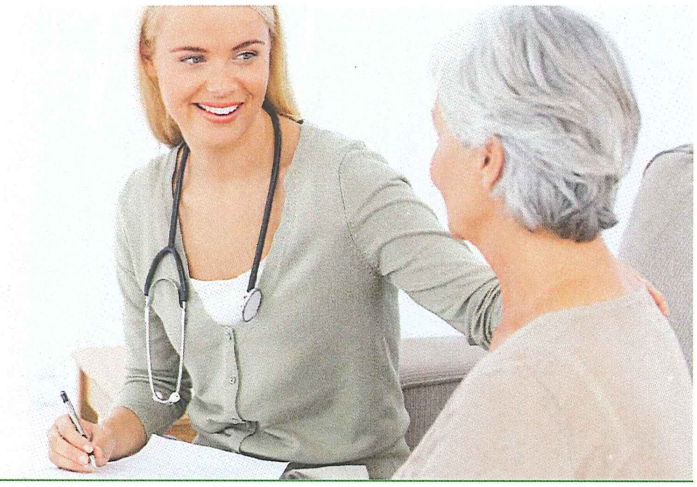
Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and FAXes of signed POLST forms are legal and valid. May make copies for records

OVER ▶

Know your Choices Ask your Doctor



Know Your Choices - Ask Your Doctor is a statewide campaign sponsored by the Washington State Medical Association (WSMA) to educate patients on important health topics and give them tools to have meaningful conversations with their physicians about appropriate care choices.

www.Know-Your-Choices.org

The campaign promotes 3 health initiatives:

Choosing Wisely®

An initiative of the ABIM Foundation

Choosing Wisely®

Physicians believe the best health care decisions should be made through meaningful conversations with patients. Evidence-based medicine is more than just using clinically proven procedures. Equally important is using the evidence to decide what *not* to do. Having a dialogue with patients about their care goals and how we can achieve them is more effective than opting for the latest test or procedure highlighted on TV.

Participating specialty societies have each identified five tests/procedures commonly used in their fields whose necessity should be questioned and discussed between physician and patient. Choosing Wisely is a national program sponsored by the **ABIM Foundation** to promote these types of conversations. We are working with the Puget Sound Health Alliance, Washington State Hospital Association, and others to promote the program.

Washington State Medical Association | WSMA

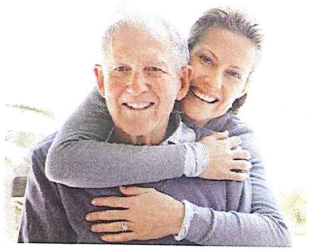
Physician Driven
Patient Focused

ER is for Emergencies

When illness, accidents, and injuries happen, do patients know the best place to go for care – doctor's office, urgent care clinic, or emergency room? Where they go matters. The goal of this campaign is to reduce unnecessary ED use by re-directing care to the appropriate setting.

End of Life Choices and Palliative Care

Many people have clear ideas of their end-of-life preferences, but few share these with family and physicians. Advance care planning documents are designed to preserve a patient's final wishes. *Advance Directives* ("living will" and durable power of attorney for health care) and the Physician Orders for Life-Sustaining Treatment (POLST) form are oral and written instructions about your future medical care in the event you are unable to express your medical wishes.



Every person over the age of 18 should consider preparing a directive to let family and physicians know their wishes.

www.Know-Your-Choices.org

Frequently asked questions regarding the POLST form

What is the POLST form? The POLST form is intended for any individual with an advanced life-limiting illness. The Physician Orders for Life-Sustaining Treatment (POLST) form represents a way of summarizing wishes of an individual regarding life-sustaining treatment.

If you have serious health concerns or conditions, you need to make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders and write order that indicate what types of life-sustaining treatment you want or do not want at the end of life.

Does the POLST form need to be signed? Yes. A physician, nurse practitioner or certified physician assistant (PA-C) **must** sign the bright green form in order for it to be a physician order that is understood and followed by other health care professionals.

If I have a signed POLST form do I need an advanced directive too? It is recommended that you also have an Advance Directive, though it is not required. You may obtain more information about advanced directives from your physician.

What if my loved one can no longer communicate his/her wishes for care? If you are the designated health care representative, you can speak on behalf of your loved one. A physician can complete the POLST form based on your understanding of your loved one's wishes.

In what setting is the POLST form used? The completed POLST form is a physician order that will remain with you if you are transported between care settings, regardless of whether you are in the hospital, at home or in a long-term care facility

Where is the POLST form kept? If you live at home, you should keep this packet with the SIGNED POLST form on the front of the refrigerator door or in a prominent location where it will be easily seen. It will be recognized by emergency personnel as orders to be followed. If you reside in a long-term facility, it may be kept in your medical chart along with other medical orders