

Office of Developmental Disabilities Services

Oregon POLST® (Portable Orders for Life-Sustaining Treatment)

- POLST stands for Portable (or Physician) Orders for Life-Sustaining Treatment. It is a form that turns a person's medical treatment preferences into a medical order.
- A doctor may bring up a POLST if someone is seriously ill and nearing the end of their life. It documents what types of medical treatments and life support a person wants to treat their serious illness and records their preferences around receiving CPR (cardiopulmonary resuscitation) if they stop breathing.
- A POLST is **not** appropriate for someone with a disability just because they have a disability. It is only for people with serious conditions like cancer or advanced heart disease, who want to make sure their treatment preferences are honored near the end of their life. POLST is only appropriate for individuals who are seriously ill and near the end of life.
- **POLST Forms are always voluntary.**
 - POLST forms should **never** be mandatory or a pre-condition to admission for any DD-licensed adult foster home or group home.
 - Hospitals and health care professionals cannot require completion of a POLST in order to receive treatment or care. ODDS providers also cannot require completion of a POLST. It is illegal and unethical to coerce or unduly influence a person to complete a POLST.
- **A person must have an opportunity to make a fully informed choice regarding completion of a POLST.**
 - Individuals should **never** be given blank POLST forms to complete.
 - POLST should be the result of a conversation. A POLST form should only be completed after a person has had a conversation with a health care professional, and any designated supporters.
 - A person with an intellectual or developmental disability has the right to identify at least three supporters and have one of them with present with them in the hospital. A hospital must ensure that the supporter designated by the person is present for any discussion



regarding the creation of a POLST, advance directive, or any other documented decision to withhold or withdraw life sustaining treatment, unless the person requests to have the discussion outside of the presence of a support person.

- Individuals who are not seriously ill, or near end of life, may still want to consider documenting treatment preferences and designated supporters. Documenting this in advance can be done through an Advance Directive, an [appointment of a healthcare representative](#), or other tools for documenting preferences for medical treatment. See [key differences between Advance Directives and POLST](#).
- It is the responsibility of the medical professional to confirm that POLST orders reflect the individual's wishes in their current state of health and to assure that a copy of the form is submitted to the [Oregon POLST Registry](#).
- A copy should also be maintained in the individual's file with case management and the residential provider, and readily available for EMTs in an emergency. A copy should also be taken with the person if they go to the doctor or to the emergency department.
- If a person goes to the hospital, the ODDS residential service provider notifies the case manager. The case manager has an obligation to share information regarding the person's preferences for treatment with the health care team.
- A health care representative, attending physician, or attending health care provider statutorily appointed under [ORS 127.635\(2\) or \(3\)](#) to make a decision to withhold or withdraw life-sustaining treatment for a person who has an intellectual or developmental disability must notify the case manager before life sustaining procedures may be withheld or withdrawn. The case manager must share with the health care team information related to the person's preferences and belief related to withholding or withdrawing life-sustaining treatment.
- Direct Support Professionals (DSPs), foster care providers, and personal support workers are expected to follow the POLST document, including when or when not to engage in CPR. A DSP following a POLST with a DNR (Do not Resuscitate) order shall not initiate CPR for a person who is not breathing and is unresponsive. [PT-20-011](#).
- Additional training and information can be found here:
 - Oregon POLST Professional Resource Library: <https://oregonpolst.org/professional-resource-library>
 - Guidebook on POLST use for persons with disabilities who are near the end of their life: <https://static1.squarespace.com/static/52dc687be4b032209172e33e/t/5f283100885c1c045abad9cd/1596469514312/POLST+for+DD+2020+rev.+v7.2+08.03.2020.pdf>
 - POLST YouTube channel with videos for health care providers, patients, and families. See here: <https://www.youtube.com/user/ORPOLST>.
 - A new [Oregon POLST form](#) became effective on January 2, 2019. All completed earlier versions of Oregon POLST forms remain valid, and existing POLST orders remain in the Oregon POLST Registry until changed or voided.

Health Care Decision-Making: Making the Decision to Withhold or Withdraw Life-Sustaining Treatment

