ALLIED HEALTH SOLUTIONS MEDICAL GROUP
301 N Prairie Avenue, Suite 230
Inglewood, CA 90301
Tel: 323 944 0949, FAX•.323 782 0388

Dear Patient,

Attached are the following Intake documents needed to establish your medical care with our healthcare

1. Patient Information Sheet
2. List of current medications
3. Medical History
4. PHQ-9 /GAD-7
5. Pain Assessment
6. Authorization to Release Medical Records
7. Social Need Screening Tool
8. HITS (Females only)
9. HIV Consent to Screen
10. Hepatitis Risk Assessment Tool
11. Informed Consent for Invasive, Diagnostic, Medical and Surgical Procedures
12. HIPAA Compliance Patient Consent Form
13. TB Risk Assessment Questionnaire
14. POLST

If you have any questions regarding the completion of these forms, please feel free to ask our Front Desk or Intake staff.

PATIENT INFORMATION SHEET

1. Patient Information

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

SEX: **(Please circle)** Male Female AGE: _____

NATIONALITY **(Please circle)** Caucasian Black Indian Asian Hispanic
Other: _____

ADDRESS: _____ CITY: _____ STATE___ ZIP: _____

CELLPHONE: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ SOCIAL SECURITY No: _____

LANGUAGE: _____

EMERGENCY CONTACT NAME /NUMBER: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ BUS PHONE: _____

2. Medical Insurance Information (optional)

MEDICAL INSURANCE: (PRIMARY): _____ POLICY NO: _____

ADDRESS OF INSURANCE CO: _____ PHONE: _____

3. Authorization Agreement

The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for service when rendered, unless arrangements are made in advance.

I hereby request and consent to diagnostic procedures, including CHDP examinations, XRAYS, blood tests, medical treatments, including immunizations.

I (self or parent/legal guardian) hereby authorize Allied Health Solutions to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered. I agree to settle all claims by arbitration.

Name: _____ Date: _____

Medical History

1. Name: _____ Age: _____
2. Date of Birth: _____
3. Date: _____
4. Marital Status: _____
5. Number of Children: _____
6. Hospitalizations: _____
7. Surgeries: _____
8. What kind of surgeries? _____
9. Allergies: _____
10. Are you currently taking any medications: _____
11. Do you drink alcohol? _____ Do you smoke_____
12. When was your last TB shot? _____
13. When was your last tetanus shot? _____
14. Have you had any of the problems below?

Chicken Pox_____
Ear infection_____
Sinus problems_____
Hay fever_____
Pneumonia_____
Sickle Cell_____
Frequent headaches_____
Anemia_____
Overweight_____
Underweight_____
Epilepsy_____
Seizure Disorders_____
Mumps_____
Bladder Infections_____
Eczema_____
Heart Murmur_____
Vision Problem_____
Wandering Eye_____

Allied Health Solutions Medical Group

Name_____

Date: _____

Date of Birth: _____

MEDICATIONS	DATE BEGAN	DIRECTIONS

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Pain Assessment

Name:_____
Date:_____
Date of Birth:_____

Location of pain: #1_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|
Location of pain: #2_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|
Location of pain: #3_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ ☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|

Allied Health Solutions Medical Group

301 N Prairie Avenue, Suite 230, Inglewood, CA 90301
Tel: 323-944-0949, Fax: 323-782-0388

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization allows the healthcare provider (s) named below to release confidential information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION
I hereby authorize:

_____

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: ALLIED HEALTH SOLUTIONS MEDICAL GROUP
Address: _301 N Prairie Ave, Unit 230
City: Inglewood_____ State: California_____ Zip Code: ___90301_____
The medical information will be used for the following purpose: _____
This authorization is:
[] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[] Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse_____(Initial) **Tests for Antibodies to HIV_____(Initial)**
Psychiatric/Mental Health _____(Initial) **HIV Diagnosis/Treatment _____(Initial)**

DURATION: This authorization shall be effective immediately and remain in effect until_____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative **Relationship if other than patient**

_____ _____
Patient's Full Name **Date**

_____ _____
Patient's Social Security Number **Patient's Date of Birth**

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2) which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Name: _____

Date of Birth: _____

Date: _____

Allied Health Solution Medical Group
301 N. Prairie Ave. Suite 230
Inglewood, CA 90301

Social Need Screening Tool

PATIENT FORM (short version) Please answer the following.

HOUSING

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future.
   - ☐ I have housing.

2. Think about the place where you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes.
   - ☐ Inadequate heat
   - ☐ Oven or stove not working.
   - ☐ No or not working smoke detectors.
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply) ☐ Yes, it has kept me from medical appointments or getting medications.
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need.

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - ☐ Yes
   - ☐ Already shut off

PERSONAL SAFETY

7. How often is anyone, including family, physically hurt?
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?

- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

10. How often does anyone, including family, scream or curse at you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

ASSISTANCE

11. Would you like to help with any of these needs?

Health Solution Medical Group
301 N. Prairie Ave. Suite 230
Inglewood, CA 90301

HEALTH PROFESSIONAL OUTREACH PROJECT

HURT, INSULT, THREATEN, and SCREAM
(HITS) Tool for Intimate Partner Violence Screening

How often does your partner?	NEVER	RARELY	SOMETIMES	FAIRLY OFTEN	FREQUENTLY
	(1)	2	(3)	4	5)
1. Physically hurt you?					
2. Insult or talk down to you?					
3. Threaten you with harm?					
4. Scream or curse at you?					
5. (+) Force you to do sexual acts that you are not comfortable with?					
TOTAL SCORE					

- (+) Added question to capture sexual violence
- Each item is scored 1-5.
- Range between 4-20.
- A score greater than 10 is considered positive.

Background:

HITS was developed by Kevin Sherin, James Sinacore, Xiao-Quiang Li, Robert Zitter, and Amer Shakil in 1998. It was first tested in a female population at Christ Hospital in Chicago and involved family physicians and family practice offices. Since the screening tool has been evaluated in diverse outpatient settings and internal reliability and concurrent validity have been tested and found to be acceptable.

The 2012 Annals of Internal Medicine's "Systematic Review of Evidence to Update the 2004 U.S. Preventative Services Task Force Recommendations," reviewed 36 studies about IPV screening in health care settings and determined that there are effective screening tools, that screening tools do not cause significant harm, and that some interventions, primarily for pregnant or post-partum women, have had positive results. The review examined 15 studies that evaluated 13 existing screening instruments. HITS was among the six instruments found to be highly accurate and recommended for use by the U.S. Preventative Service Task Force (USPSTF).

The USPSTF recommends that women of childbearing age be screened for intimate partner violence and women who screen positive be provided or referred for intervention services. This recommendation applies to women who do not have signs or symptoms of abuse. HITS was evaluated by the USPSTF and found to be among the top 6 tools that showed the most sensitivity and specificity. The HITS screen is simpler and faster than other IPV measures, which makes it more practical to use in a busy clinical setting. It is also unique in that it assesses both psychological IPV and physical aggression.

Name: _____
Date of Birth: _____
Date: _____

Allied Health Solutions Medical Group

HIV Consent to Screen

I hereby request and authorize Allied Health Solutions Medical Group to evaluate me for the possible infection with the "AIDS" virus, I further acknowledge that t have been properly counseled and advised about the test for "AIDS" and understand the legal, social, emotional, physical and professional consequences if the test is positive.

I will not hold Allied Health Solutions Medical Group or it's contracted Providers responsible for any of the above-mentioned consequences and I further understand that the test results are strictly confidential.

Patient's Full Name:

_____

Date of Birth:

_____

Patient's Signature:

_____

Witness Signature:

_____

Facility:

_____

Date:

_____

Name: _____

Date of Birth: _____

Date: _____

Hepatitis Risk Assessment Tool

"Hepatitis" means inflammation of the liver and is usually caused by a virus. In the U.S., the most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Millions of Americans are living with viral hepatitis but most do not know they are infected. People can live with chronic hepatitis for decades without having symptoms.

This assessment will help determine if you should be vaccinated and/or tested for viral hepatitis by asking a series of questions. Depending on your answers, you will be given a tailored recommendation that you should discuss with your doctor or your professional healthcare provider. Any information received through the use of this tool is not medical advice and should not be treated as such.

Questions	Recommendations & Explanation
1. Have you ever been diagnosed with a clotting factor disorder?	If yes, talk to your doctor about getting vaccinated for Hepatitis A.
2. Have you ever been diagnosed with a chronic liver disease?	If yes, talk to your doctor about getting vaccinated for Hepatitis A and B.
3. Were you or at least one parent born outside of the United States?	If yes, talk to a doctor about getting a blood test for Hepatitis B. Many parts of the world have high rates of hepatitis B, including the Amazon Basin, parts of Asia, Sub-Saharan Africa and the Pacific Islands.
4. Do you currently live with someone who is diagnosed with Hepatitis B?	If yes, talk to a doctor about getting a blood test for Hepatitis B.
5. Have you previously lived with someone who has been diagnosed with hepatitis B?	If yes, talk to a doctor about getting a blood test for hepatitis B.
6. Have you recently been diagnosed with a sexually transmitted disease (STD)?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
7. Have you been diagnosed with diabetes?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
8. Have you been diagnosed with HIV/AIDS?	If yes, talk to a doctor about getting vaccinated for Hepatitis B and getting a blood test for Hepatitis B and Hepatitis C.
9. If you are a man, do you have sexual encounters with other men?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B.
10. Do you currently inject drugs?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B and C.
11. Were you born from 1945-1965?	If yes, talk to a doctor about getting a blood test for Hepatitis C
12. Have you ever received a blood transfusion or organ transplant before July 1992?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
13. Have you ever received a clotting factor concentrate before 1987?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
14. Have you ever injected drugs, even if just once?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
15. Do you plan on traveling outside of the United States within the next year?	If yes, talk to a doctor about what vaccines may be needed for travel outside the U.S.

Facility: Allied Health Solutions Medical Group

INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES

Name: _____

Date of Birth: _____

Date: _____

FORM B-1

I hereby permit _____ (Name of Attending Physician or Authorized Health Care Provider) or his/her Associate Attending Physician of the same service, and assistants as may be selected and supervised by him/her to perform the following medical treatment, operation, or procedure (hereafter called the "procedure"):

_____

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure. If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment which is necessary.

I agree to have transfusions of blood and other blood products that may be necessary along with the procedure I am having. The risks, benefits and alternatives have been explained to me and all of my questions have been answered to my satisfaction.

If I refuse to have transfusions I will cross out and initial this section and sign a REFUSAL OF TREATMENT form.

I agree to allow this facility to keep, use or properly dispose of, tissue and parts of organs that are removed during this procedure.

_____ _____ and _____ am pm

Signature of Patient or Parent/Legal Guardian of Minor Patient | **Date** | **Time**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____ and _____ am pm

Signature of Health Care Agent/Legal Guardian | **Date** | **Time**

(Place a copy of the authorizing document in the medical record)

_____ _____ and _____ am pm

Signature and Relation of Surrogate | **Date** | **Time**

WITNESS:

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ _____ and _____ am pm

Signature and Title of Witness | **Date** | **Time**

INTERPRETER/TRANSLATOR: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ _____ and _____ am pm

Signature of Interpreter/Translator | **Date** | **Time**

Name: _____

Date of Birth: _____

Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse, nurse practitioner)

Name: _____

Date of Birth: _____ Date of Risk Assessment: _____

History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.

If there is a "Yes" response to any of the questions #1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Foreign-born person (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Traveler to high TB-prevalence country for more than 1 month (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

CERTIFICATE OF COMPLETION

(To be signed by health care provider completing the risk assessment and/or examination)

Name: _____

Date of Birth: _____ **Date of Risk Assessment:** _____

The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified has been examined and determined to be free of infectious tuberculosis.

_____

Health Care Provider Signature **Date**

_____

Health Care Provider Name **Title**

_____

Office Address: Street **City** **State** **Zip Code**

_____

Telephone **Fax**

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

Physician Orders for Life-Sustaining Treatment (POLST)

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

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 — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

Check One

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

Check One

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

Check One

☐ 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 #:	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