伊利诺伊州 - 公共卫生部
（Department of Public Health）

伊利诺伊州公共卫生部（IDPH）
统一生命维持治疗医嘱（POLST）表

病人请注意：*请在完全自愿的情况下填写本表。如有需要，请在您信任的人士的陪同下，与医疗服务专业人员讨论是否签署生命维持治疗医嘱（POLST）表。**医疗服务机构请注意：**请在与病人或其代理人沟通后填写本表。生命维持治疗医嘱决策过程适用于具有严重的影响寿命的健康状况，且随时可能发生危及生命的临床事件的病人，其中可能包括老年衰弱的病人。当病情发生重大变化时，病人可能需要重新填写生命维持治疗医嘱表。*

病人信息。*病人请注意：请在完全自愿的情况下填写本表。*			
病人姓氏	病人名字		病人中间名
出生日期（月/日/年）	地址（街道/城市/州/邮政编码）		

A *必选一项*	**病人出现心脏骤停时的医嘱。**前提是病人已无脉搏。	
	☐ **施行人工心肺复苏术：尝试施行人工心肺复苏术（CPR）。**按照标准医疗方案使用所有指定的治疗方法。（勾选本项者，必须勾选 B 部分的**全程疗护（Full Treatment）**。）	☐ **不施行人工心肺复苏术：不尝试施行人工心肺复苏术（DNAR）。**
B *选填项，视情况而定*	**病人未出现心脏骤停时的医嘱。**前提是病人仍有脉搏。无论选择哪种治疗方案，均应最大限度地提高治疗的舒适度。（如未勾选任何选项，将默认为选择全程疗护。）	
	☐ **全程疗护：首要目标是尝试通过使用所有指定治疗方法来防止病人出现心脏骤停。**包括使用气管插管、机械通气、心脏整流和所有其他指定的治疗方法。 ☐ **选择疗护：首要目标是通过有限的医疗措施来缓解病情。**不做插管或使用侵入性呼吸器。可以使用非侵入性的正压呼吸器，包括持续气道正压通气（CPAP）和双水平正压通气（BiPAP）。可根据需要给予静脉输液、抗生素、血管加压药和抗心律失常药。在必要情况下转送医院。 ☐ **只要舒适疗护：首要目标是通过症状管理最大限度地提高舒适度。允许自然死亡。**根据需要以任何方式用药。使用吸氧、抽痰以及人工治疗呼吸道阻塞。除非符合舒适度目标，否则不要使用全程疗护和选择疗护中列出的治疗。只有在当前环境中无法满足舒适度时，才转送医院。	
C *选填项，视情况而定*	**补充医嘱或指示。**本节是对上述医嘱的补充（例如，不输血；不做透析）。[地区急救人员协议可能会限制急救人员根据本节所填医嘱来行事的能力。]	
D *选填项，视情况而定*	**关于人工输入营养。**在可行的情况下，用嘴进食。（如未勾选任何选项，默认为提供标准护理。）	
	☐ 通过任何人工方式提供营养和水分补充，包括使用新的或现有的灌食管。 ☐ 尝试人工方式提供营养和水分补充一段时间，但不包括使用灌食管。 ☐ 不使用人工方式提供营养或水分补充。	
E *必选项*	***病人或法定代理人签名。****（电子签名文件有效。）*	
	X 正楷书写姓名 ***（必填）*** [redacted]	日期 [redacted]
	*签名 **（必填）** 本人已与医疗服务专业人员讨论了治疗方案和护理目标。如由法定代理人签名，据本人所知所信，所选择的治疗方案和病人的意愿是一致的。* **X** [redacted]	
	签名人与病人的关系： ☐ 病人 ☐ 未成年人的父母	☐ 医疗服务之委托代理人 ☐ 医疗服务之代理决策者（优先级列表，请参阅第 2 页）
F *必选项*	***符合资格的医疗服务从业者。****医师、持照住院医师（两年或两年以上经验）、高级执业护士或医师助理。（电子签名文件有效。）*	
	X 授权执业医师正楷书写姓名 ***（必填）*** [redacted]	电话 [redacted]

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

- ☐ **YES CPR**: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)
- ☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

- ☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
- ☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
- ☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use 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. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

- ☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
- ☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.
- ☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)*** | Date _____

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient:
☐ Patient
☐ Parent of minor
☐ Agent under Power of Attorney for Health Care
☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)*** | Phone _____

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.*

X

Date ***(required)*** _____

	授权执业医师签名 ***（必填）***，*据本人所知所信，这些医嘱与病人的医疗状况和意愿是一致的。*	日期 ***（必填）***
	X [redacted]	[redacted]

*****本页为可选内容，仅用于参考之目的*****

病人姓氏	病人名字	病人中间名

病人应在完全自愿的情况下填写伊利诺伊州公共卫生部（IDPH）生命维持治疗医嘱（POLST）表。本表记录了病人在当前健康状况下的医疗意愿。病人或其代理人和医疗服务机构应定期重新评估和讨论相关干预措施，以确保治疗符合病人的护理目标。本表可以随时更改以反映病人的新意愿。
本表无法涵盖病人可能需要做出的所有医疗决策。建议所有具有自主能力的成年人签署《医疗预先指令授权书》（POAHC），无论其健康状况如何。《医疗预先指令授权书》允许病人做出详细的未来医疗指示，并指定一名法定代理人，以在病人失去自主能力时，代表其做出决定。

填写本表时，病人可签署以下预先指令授权书			
☐ 医疗服务委托书	☐ 生前遗嘱声明	☐ 心理健康治疗声明	☐ 不适用

医疗服务专业人员信息	
填表人姓名	电话号码
填表人职务	填表日期

关于填写伊利诺伊州公共卫生部（IDPH）生命维持治疗医嘱（POLST）表

- 病人应在完全自愿的情况下填写生命维持治疗医嘱表，不得强制要求病人填表，且病人可以随时更改其意愿。
- 生命维持治疗医嘱表应反映填表人的当前意愿；建议病人填写一份《医疗预先指令授权书》（POAHC）。
- 病人或其法定代理人可通过口头/电话同意的方式完成生命维持治疗医嘱表的填写。
- 允许以口头/电话方式填写生命维持治疗医嘱表，并由授权执业医师根据机构/社区的相应政策进行后续的签名。
- 建议使用原始表格。电子副本和复印件，包括传真件，均合法有效，无论纸张颜色如何。
- 带有电子签名的表格视为合法有效。
- 符合资格的医疗服务从业者可以是在伊利诺伊州获得的执照或在病人接受治疗的州获得的执照。

生命维持治疗医嘱（POLST）表之审议

应根据病人的当前需求和意愿定期对生命维持治疗医嘱表进行审议。其中包括：

- 从一个护理环境或护理级别转移到另一个护理环境或护理级别；
- 病人的健康状况发生变化或使用了植入设备（如埋藏式心脏复律除颤器（ICD）/脑刺激器）；
- 病人的当前的治疗和偏好；和
- 病人的初级护理专业人员发生变化。

关于作废或撤销生命维持治疗医嘱（POLST）表

- 具有自主能力的病人可以作废或撤销填写的生命维持治疗医嘱表，和/或请求其他治疗方法。
- 更改、修改或修订生命维持治疗医嘱表后，需填写新的生命维持治疗医嘱表。
- 如果病人填写了新的生命维持治疗医嘱表，或生命维持治疗医嘱表失效，则应在 A 部分至 E 部分划一条线，并在页面上写上“无效”字样。
- 在“无效”字样下方写上变更日期并重新签名。
- 如果生命维持治疗医嘱表归档在电子病历中，请遵循医疗机构的所有作废程序。

伊利诺伊州医疗服务代理法案（755 ILCS 40/25）优先级

1.病人的监护人
2.病人的配偶或已登记伴侣关系的伴侣
3.成年子女
4.父母
5.成年的兄弟姐妹
6.成年孙辈
7.病人的好友
8.病人的遗产监护人
9.根据 1987 年《青少年法庭法》第 2-10 节第（2）小节指定的病人临时监护人，前提是法庭已根据 1987 年《青少年法庭法》第 2-10 节第（12）小节发出授予该临时监护人此类权力的命令。

更多信息，请访问伊利诺伊州公共卫生部法律声明，网址为 http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA（1996 年《健康保险可携性和责任法案》）
允许向医疗服务专业人员披露治疗所需的信息

****THIS PAGE IS OPTIONAL – use for informational purposes****		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT