伊利諾州 - 公共衛生部
（Department of Public Health）

伊利諾州公共衛生部（IDPH）
統一生命維持治療醫囑（POLST）表

***病人請注意：**請在完全自願的情況下填寫本表。如有需要，請在您信任的人士的陪同下，與醫療服務專業人員討論是否簽署生命維持治療醫囑（POLST）表。**醫療服務機構請注意：**請在與病人或其代理人溝通後填寫本表。生命維持治療醫囑決策過程適用於具有嚴重的影響壽命的健康狀況，且隨時可能發生危及生命的臨床事件的病人，其中可能包括老年衰弱的病人。當病情發生重大變化時，病人可能需要重新填寫生命維持治療醫囑表。*

***病人信息。**病人請注意：請在完全自願的情況下填寫本表。*

病人姓氏	病人名字	病人中間名

出生日期（月/日/年）	地址（街道/城市/州/郵政編碼）

A *必選一項*

病人出現心臟驟停時的醫囑。前提是病人已無脈搏。

- ☐ **施行人工心肺復甦術：嘗試施行人工心肺復甦術（CPR）。**按照標準醫療方案使用所有指定的治療方法。（勾選本項者，必須勾選 B 部分的**全程療護（Full Treatment）**。）
- ☐ **不施行人工心肺復甦術：不嘗試施行心肺復甦術（DNAR）。**

B *選填項，視情況而定*

病人未出現心臟驟停時的醫囑。前提是病人仍有脈搏。無論選擇哪種治療方案，均應最大限度地提高治療的舒適度。（如未勾選任何選項，將默認為選擇全程療護。）

- ☐ **全程療護：首要目標是嘗試通過使用所有指定治療方法來防止病人出現心臟驟停。**包括使用氣管插管、機械通氣、心臟整流和所有其他指定的治療方法。
- ☐ **選擇療護：首要目標是通過有限的醫療措施來緩解病情。**不做插管或使用侵入性呼吸器。可以使用非侵入性的正壓呼吸器，包括持續正壓（CPAP）和雙式正壓（BiPAP）。可根據需要給予靜脈輸液、抗生素、升壓劑和抗心律不整劑。在必要情況下轉送醫院。
- ☐ **只要舒適療護：首要目標是通過症狀管理最大限度地提高舒適度。允許自然死亡。**根據需要以任何方式用藥。使用吸氧、抽痰以及人工治療呼吸道阻塞。除非符合舒適度目標，否則不要使用全程療護和選擇療護中列出的治療。只有在當前環境中無法滿足舒適度時，才轉送醫院。

C *選填項，視情況而定*

補充醫囑或指示。本節是對上述醫囑的補充（例如，不輸血；不做透析）。[地區急救人員協議可能會限制急救人員根據本節所填醫囑來行事的能力。]

D *選填項，視情況而定*

關於人工輸入營養。在可行的情況下，用嘴進食。（如未勾選任何選項，默認為提供標準護理。）

- ☐ 通過任何人工方式提供營養和水分補充，包括使用新的或現有的灌食管。
- ☐ 嘗試人工方式提供營養和水分補充一段時間，但不包括使用灌食管。
- ☐ 不使用人工方式提供營養或水分補充。

E *必選項*

***病人或法定代理人簽名。**（電子簽名文件有效。）*

X 正楷書寫姓名*（必填）*	日期 ________________

簽名*（必填）本人已與醫療服務專業人員討論了治療方案和護理目標。如由法定代理人簽名，據本人所知所信，所選擇的治療方案和病人的意願是一致的。*

X

簽名人與病人的關係： ☐ 病人 ☐ 未成年人的父母	☐ 醫療服務之委託代理人	☐ 醫療服務之代理決策者（優先級列表，請參閱第 2 頁）

F *必選項*

***符合資格的醫療服務從業者。**醫師、持照住院醫師（兩年或兩年以上經驗）、高級執業護士或醫師助理。（電子簽名文件有效。）*

X 授權執業醫師正楷書寫姓名*（必填）*	電話 ________________

FOR TRANSLATION ONLY
COMPLETE AND SIGN ENGLISH PRACTITIONER ORDER
FOR LIFE-SUSTAINING TREATMENT FORM

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)*** ____________________

	授權執業醫師簽名 *（必填）*，*據本人所知所信，這些醫囑與病人的醫療狀況和意願是一致的。* **x**	日期 *（必填）* ______________

*****本頁為可選內容，僅用於參考之目的*****

病人姓氏	病人名字	病人中間名

病人應在完全自願的情況下填寫伊利諾州公共衛生部（IDPH）生命維持治療醫囑（POLST）表。本表記錄了病人在當前健康狀況下的醫療意願。病人或其代理人和醫療服務機構應定期重新評估和討論相關干預措施，以確保治療符合病人的護理目標。本表可以隨時更改以反映病人的新意願。
本表無法涵蓋病人可能需要做出的所有醫療決策。建議所有具有自主能力的成年人簽署《醫療預先指令授權書》（POAHC），無論其健康狀況如何。《醫療預先指令授權書》允許病人做出詳細的未來醫療指示，並指定一名法定代理人，以在病人失去自主能力時，代表其做出決定。

填寫本表時，病人可簽署以下預先指令授權書

☐ 醫療服務委託書	☐ 生前遺囑聲明	☐ 心理健康治療聲明	☐ 不適用

醫療服務專業人員信息

填表人姓名	電話號碼
填表人職務	填表日期

關於填寫伊利諾州公共衛生部（IDPH）生命維持治療醫囑（POLST）表

- 病人應在完全自願的情況下填寫生命維持治療醫囑表，不得強制要求病人填表，且病人可以隨時更改其意願。
- 生命維持治療醫囑表應反映填表人的當前意願；建議病人填寫一份《醫療預先指令授權書》（POAHC）。
- 病人或其法定代理人可通過口頭/電話同意的方式完成生命維持治療醫囑表的填寫。
- 允許以口頭/電話方式填寫生命維持治療醫囑表，並由授權執業醫師根據機構/社區的相應政策進行後續的簽名。
- 建議使用原始表格。電子副本和複印件，包括傳真件，均合法有效，無論紙張顏色如何。
- 帶有電子簽名的表格視為合法有效。
- 符合資格的醫療服務從業者可以是在伊利諾州獲得的執照或在病人接受治療的州獲得的執照。

生命維持治療醫囑（POLST）表之審議

應根據病人的當前需求和意願定期對生命維持治療醫囑表進行審議。其中包括：

- 從一個護理環境或護理級別轉移到另一個護理環境或護理級別；
- 病人的健康狀況發生變化或使用了植入設備（如埋藏式心脏复律除颤器（ICD）/腦刺激器）；
- 病人的當前的治療和偏好；和
- 病人的初級護理專業人員發生變化。

關於作廢或撤銷生命維持治療醫囑（POLST）表

- 具有自主能力的病人可以作廢或撤銷填寫的生命維持治療醫囑表，和/或請求其他治療方法。
- 更改、修改或修訂生命維持治療醫囑表後，需填寫新的生命維持治療醫囑表。
- 如果病人填寫了新的生命維持治療醫囑表，或生命維持治療醫囑表失效，則應在 A 部分至 E 部分劃一條線，並在頁面上寫上"無效"字樣。
- 在"無效"字樣下方寫上變更日期並重新簽名。
- 如果生命維持治療醫囑表歸檔在電子病歷中，請遵循醫療機構的所有作廢程序。

伊利諾州醫療服務代理法案（755 ILCS 40/25）優先級

1.病人的監護人
2.病人的配偶或已登記伴侶關係的伴侶
3.成年子女
4.父母
5.成年的兄弟姐妹
6.成年孫輩
7.病人的好友
8.病人的遺產監護人
9.根據 1987 年《青少年法庭法》第 2-10 節第（2）小節指定的病人臨時監護人，前提是法庭已根據 1987 年《青少年法庭法》第 2-10 節第（12）小節發出授予該臨時監護人此類權力的命令。

更多信息，請訪問伊利諾州公共衛生部法律聲明，網址為 http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA（1996 年《健康保險可攜性和責任法案》）
允許向醫療服務專業人員披露治療所需的信息

COMPLETE FORM IN ENGLISH FOR PRACTITIONER ORDER
FOR TRANSLATION ONLY
FOR REFERENCE SIGNING / LIFE-SUSTAINING TREATMENT FORM

*****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