Triage Health Estate Planning Toolkit: Oregon

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Oregon probate courts accept written wills. To make a valid written will in Oregon:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old, or who has been lawfully married, or an emancipated minor
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. You need to sign the will, in front of two witnesses who watched you sign the will. Oregon law does not prevent a beneficiary from acting as a witness to a will, but experts recommend choosing a witness who is not included in your will.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a notarized statement that it was your intention to make the will and you did so without undue or coercive influence.

Oregon now allows you to notarize your self-proving will remotely. Under limited circumstances, it may be possible for a handwritten will to be valid in Oregon. However, most estate planning experts do not recommend relying on handwritten wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on behalf of the principal.

In Oregon, a general power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. This document can either go into effect when you sign it, or you can designate that it will take effect at some point in the future (e.g., if you become incapacitated.) After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. The Oregon advance health care directive includes four parts (A, B, C, and D). You can fill out Part B and Part C, or just one of the two. You need to sign Part D to make the document legal.

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- **Part A:** This section includes important information you should read before completing your directive, including your right to revoke this document at any time and that it will not expire until you do so. It also allows you to indicate if you would like this document to be in effect for your entire life, or for a certain period of time.
- **Part B Appointing a Health Care Representative:** This document lets you choose someone (your "health care representative") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can appoint an alternate person to make these decisions if the first person you chose isn't available. You can also include instructions for specific situations, including life-sustaining care, to guide your agent.
- **Part C Health Care Instructions:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. At the end of this document, you can indicate if you would like your living will to override your proxy's decisions.
- **Part D Signing and Witnessing Provisions:** In this section, you must sign your advance health care directive to make it valid. You can either have you signature witnessed by a notary public, or two adult witnesses. If you are a resident in a long-term care facility, one of your witnesses must be a qualified person designated by your facility, complying with their Department of Human Resources rules.

You can change any other instructions included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up this directive. But, you have to tell your agent, physician, or treating health care provider that you revoked your agent's powers for it to be effective.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves, unless you affirm otherwise in a written statement.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance directive. You can complete a POLST form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Antibiotics
- Medically assisted nutrition, or hydration and food offered through surgically-placed tubes
- Your overall goals or preferences for life-sustaining care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Oregon does not have a dedicated funeral designation form, but you can use your advance health care directive to designate someone to oversee your end-of-life care.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Since 1997, Oregon's Death with Dignity Act gives certain patients the right to request compassionate, safe aid in dying. Qualified patients must:

- Be 18 years or older
- Be an Oregon resident
- Be diagnosed with an incurable terminal illness with a prognosis of six months or less to live
- Be able to make medical decisions for yourself
- Be able to take (eat, drink, swallow, or inject) the aid-in-dying medication by yourself

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 15 days apart. In extreme circumstances, this timeframe may be altered.
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- 48 hours after the request for medication form is complete, the doctor can write the prescription for the medication

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place.

If your doctor refuses to administer an aid-in-dying medication, you can find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: Oregon

Part III: Your State's Estate Planning Forms

- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

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Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

PART A

INTRODUCTION

OREGON ADVANCE DIRECTIVE FOR HEALTH CARE

• This Advance Directive form allows you to:

• Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.

• Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

• Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

• The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

• In sections 1, 2, 5, 6 and 7 you appoint a health care representative.

• In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

• If you have completed an advance directive in the past, this new advance directive will replace any older directive.

• You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

• If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

• In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

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PART 1

PRINT YOUR NAME, DATE OF BIRTH, PHONE NUMBERS, ADDRESS, AND EMAIL

1. ABOUT ME

Name: _____ Date of Birth: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

PART 2

2. MY HEALTH CARE REPRESENTATIVE

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

PRINT THE NAME, RELATIONSHIP, TELEPHONE NUMBERS, ADDRESS, AND EMAIL OF YOUR REPRESENTATIVE

Name: _____ Relationship:_____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

PRINT THE NAME, RELATIONSHIP, TELEPHONE NUMBERS, ADDRESS, AND EMAIL OF YOUR FIRST AND SECOND ALTERNATE REPRESENTATIVES

First alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

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PART 3

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU HAVE A "TERMINAL CONDITION", AS IT IS DEFINED IN THIS DOCUMENT

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3. MY HEALTH CARE INSTRUCTIONS

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.
You can provide guidance on your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. MY HEALTH CARE DECISIONS:
There are three situations below for you to express your wishes. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

a. Terminal Condition

This is what I want if:

- I have an illness that cannot be cured or reversed.

AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only.

___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced Progressive Illness

This is what I want if:

• I have an illness that is in an advanced stage.

AND

• My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

• My health care providers believe I will never be able to:

- Communicate
- Swallow food and water safely
- Care for myself
- Recognize my family and other people

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU HAVE AN "ADVANCED PROGRESSIVE ILLNESS", AS IT IS DEFINED IN THIS DOCUMENT

Initial one option only.

___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

___ I do not want treatments to sustain my life, such as artificial feeding an hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

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c. Permanently Unconscious

This is what I want if:

I am not conscious.

AND

If my health care providers believe it is very unlikely that I will ever become conscious again.

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU ARE "PERMANENTLY UNCONSCIOUS", AS IT IS DEFINED IN THIS DOCUMENT

Initial one option only.

___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

_____

_____

_____

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THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

INITIAL ANY OF THE STATEMENTS THAT ARE APPLICABLE TO YOU

ATTACH ADDITIONAL PAGES, IF NEEDED

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B. WHAT MATTERS MOST TO ME AND FOR ME:

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.

This is what you should know about what is important to me about my life:

_____

This is what I value the most about my life:

_____

This is what is important for me about my life:

_____

I do not want life-sustaining procedures if I cannot be supported and be able to engage in the following ways:

Initial all that apply.

___ Express my needs.

___ Be free from long-term severe pain and suffering.

___ Know who I am and who I am with.

___ Live without being hooked up to mechanical life support.

___ Participate in activities that have meaning to me, such as:

_____

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in . . . .)

_____
_____
_____

PART 4

THIS PART IS OPTIONAL: IT ALLOWS YOU TO PROVIDE YOUR APPOINTED REPRESENTATIVES AND HEALTH CARE PROVIDERS WITH MORE INFORMATION ABOUT YOUR VALUES, PREFERRED CARE SETTINGS, OR IMPORTANT DOCUMENTS.

ALSO OPTIONAL, SECTION D ALLOWS YOU TO LIST PEOPLE WITH WHOM YOU WOULD LIKE MEDICAL INFORMATION SHARED

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4. MORE INFORMATION

Use this section if you want your health care representative and health care providers to have more information about you.

A. LIFE AND VALUES

Below you can share about your life and values. This can help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system and more.
You may write in the space below or attach pages to say more about your life, beliefs and values.

_____
_____

B. PLACE OF CARE:

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)
You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

_____
_____

C. OTHER:

You may attach to this form other documents you think will be helpful to your health care representative and health care providers. What you attach will be part of your Advance Directive.
You may list documents you have attached in the space below.

_____
_____

D. INFORM OTHERS:

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name: _____

Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell) _____

Address: _____

E-mail:_____

PART 5

SIGN YOUR NAME AND DATE THE DOCUMENT

PART 6

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE. IN THE ALTERNATIVE, YOU MAY HAVE THIS DOCUMENT NOTARIZED BY A NOTARY PUBLIC IN THE STATE OF OREGON

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5. MY SIGNATURE

My signature: _____

Date: _____

6. WITNESS

COMPLETE EITHER A OR B WHEN YOU SIGN

A. NOTARY:

State of _____
County of _____

Signed or attested before me on _____, 2 _____, by _____.

_____
Notary Public — State of Oregon

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____

Date: _____

Witness Name (print): _____

Signature: _____

Date: _____

PART 7

YOUR REPRESENTATIVE (OR ALTERNATIVE REPRESENTATIVE(S)) MUST SIGN, DATE, AND PRINT HIS/HER/THEIR NAME(S) HERE IN ORDER FOR HIS/HER/THEIR AUTHORITY TO GO INTO EFFECT

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name:_____

Signature or other verification of acceptance:
_____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance:
_____

Date: _____

Second alternate health care representative:

Printed name:_____

Signature or other verification of acceptance:
_____

Date:_____

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Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

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OREGON ORGAN DONATION FORM — PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your health care representative or other agent, or your family, may have the authority to make a gift of all or part of your body under Oregon law.

_____I do not want to make an organ or tissue donation and I do not want my health care representative or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Oregon law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____
_____
_____

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

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HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:

Preferred Name:	Date of Birth: (mm/dd/yyyy)	Gender:	MRN (optional)
	_____ /_____ /_____	☐ M ☐ F ☐ X	

Address (street / city / state / zip):

A — CARDIOPULMONARY RESUSCITATION (CPR): *Unresponsive, pulseless & not breathing.*

Check One

☐ **Attempt Resuscitation/CPR**
Must check Full Treatment in Section B.

☐ **Do Not Attempt Resuscitation/DNR**
If patient not in cardiopulmonary arrest, follow orders in B.

B — MEDICAL INTERVENTIONS: *When patient has a pulse and is breathing.*

Check One

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.*** *Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated.
Transfer to hospital *and/or intensive care unit, if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C — DISCUSSED WITH: (REQUIRED)

Check All That Apply

☐ Patient ☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.

List all names and relationship: _____

D — PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)

Signature:	Name (print):	Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E — ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)

Must Print Name, Sign & Date

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: ***required***	Signer's Phone Number:	Signer's License Number: ***(optional)***
MD / DO / NP / PA / ND Signature: ***required*** SAMPLE 2023	Date: ***required***	**"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

*Also known as Physician Orders for Life-Sustaining Treatment

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HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information Regarding POLST

PATIENT'S NAME: _____

The POLST form is:

- **Always voluntary and cannot be required**
- **A medical order for people with a serious illness or frailty**
- An expression of wishes for emergency treatment in one's current state of health (if something happened today)
- A form that can be changed at any time, with a health care professional, to reflect new treatment wishes
- **NOT an advance directive**, which is ALSO recommended. An advance directive is the appropriate legal document to appoint a health care representative. See ORS 127.527

Contact Information (Optional)

Emergency Contact:	Relationship:	Phone Number:

Health Care Professional's Information

Preparer's Name	Preparer's Title	Phone Number:	Date Prepared:

Primary Care Professional's Name

Directions for Health Care Professionals

Completing Oregon POLST®

- Discussion and attestation should be accompanied by a note in the medical record.
- Any section not completed implies full treatment for that section.
- An order for CPR in Section A requires an order for Full Treatment in Section B, or the form will not be accepted into the Registry.
- Photocopies, faxes and electronically-signed forms are legal and valid.
- Verbal / phone orders from MD/DO/NP/PA/ND in accordance with facility/community policy can be submitted to the Registry.
- For information on determining the legal decision maker(s) for patients who lack capacity and have not appointed a health care representative, **refer to ORS 127.635**
- A person with intellectual or developmental disabilities requires additional considerations before completing the POLST form. Refer to ***Guidelines on POLST Use for Persons with Significant Disabilities who are Now Near the End of Life*** at: osf.io/f852b

Registry Contact Information:

Toll Free: 1-877-367-7657
Fax or eFAX: 503-418-2161
orpolstregistry.org
polstreg@ohsu.edu

Oregon POLST Registry
3181 SW Sam Jackson Park Rd.
Mail Code: BTE 234
Portland, OR 97239

Patients:

The Registry will mail a confirmation packet to the address listed on the front page in about four weeks.

Updating POLST: POLST forms should be reviewed regularly. A POLST form needs to be revised or voided if patient treatment preferences have changed.

POLST forms should be reviewed routinely, including when:

- The patient is transferred from one care setting or care level to another (including upon admission or at discharge), or
- There is a substantial change in the patient's health status.

If patient wishes have not changed, the POLST form does not need to be revised, updated, rewritten or resent to the Registry.

Voiding POLST: A copy of the voided POLST must be sent to the Registry unless patient opted out.

- A person with capacity, or the legal decision maker of a person without capacity, can void the form and request alternate treatment.
- For paper forms, draw a line through sections A through E and write "VOID" and the date. *Note:* Revising a POLST form automatically replaces a previous form in the Registry.
- If included in an electronic medical record, follow your system's ePOLST voiding procedures.
- Regardless of paper or ePOLST form, send a copy of the voided form to the POLST Registry (required unless patient opted out).

For permission to use the copyrighted form, contact OHSU Center for Ethics in Health Care at: polst@ohsu.edu or (503) 494-3965.

Information on the Oregon POLST Program is available online at: **oregonpolst.org** or at **polst@ohsu.edu**

Scan QR Code to access POLST completion and submission information.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

*Also known as Physician Orders for Life-Sustaining Treatment

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Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524