**ADVANCE CARE PLANNING IS FOR EVERYONE.
POLST IS FOR SERIOUS ILLNESS.**

Advance care planning is learning about different types of healthcare decisions that would need to be made if you became seriously ill or injured in the future, and then letting others know—both family and health care providers— your choices for care.

These choices are often put into an advance directive, a legal document that guides medical care in the case of disease or injury when a patient can't speak for themselves.

POLST is for people with advanced, chronic, or end-stage illness and shares your choices for treatment. With the POLST, your choices for care are turned into physician orders to make sure that you only get the treatments that you want.

Advance Care Planning Resources:
Alaska Native Tribal Health Consortium
Advance Care Planning Resources
anthc.org

Providence Institute for Human Caring
instituteforhumancaring.org

Alaska Advance Health Care Directive
dhss.alaska.gov/dph/Director/Documents/advancedirective.pdf

Organizations that endorse the use of POLST in Alaska:

State of Alaska, Department of Health & Social Services • Alaska State Hospital & Nursing Home Association (ASHNHA) • Alaska State Medical Association • Alaska Hospice & Palliative Nurse Association • National POLST

AKPOLST.ORG

Quick Guide for Patients & Families

What is the purpose of the POLST?
If you have a serious health condition, you should consider making decisions about the types of treatment you want before you have a medical emergency.

Your physician may use the POLST to write orders that share your goals for care and what types of life-sustaining treatment you want or do not want.

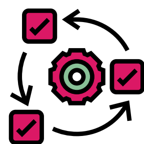
- POLST is voluntary and optional.
- POLST is a medical order that is required to be honored by all health care professionals in Alaska.
- You can change or void your POLST form at any time.

POLST can help you make decisions about treatment you would want in case of a medical emergency.

- Are you okay going to the hospital?
- Would you rather stay where you are?
- Are you okay going into the intensive care unit and possibly being on a breathing machine?
- Would you want to avoid treatments that may be burdensome if they are unlikely to help you recover?

You decide what fits you best.

POLST IS



A PROCESS.

Part of advance care planning, which helps individuals live the best life possible.

A CONVERSATION.

Communication between providers and patients about a patient's medical condition, treatment options, and wishes.

A FORM.

A medical order form that travels with a patient (called a POLST form).

You or your health care provider can download the POLST form and get more information about POLST at **www.akpolst.org.**

How does the POLST work?
The most important part of POLST is the discussion between you and your health care provider. This talk should cover your diagnosis and medical condition, treatment options, and goals for care.

Based on this conversation, your provider will take the decisions you've made about your treatment wishes and turn those into medical orders by filling out a POLST form.

A physician must sign the form for it to become a medical order.

How do I make sure these medical orders are honored?
The completed POLST is a medical order form that stays with you if you are moved between care settings. It can be honored in your home, in long-term care facilities, and if you are admitted to a hospital.

If you live at home, you should keep the POLST in a place where it can be easily found (e.g., on the front of the refrigerator.) It should also be kept in your medical chart by your primary care provider and members of your health care team. Your surrogate/healthcare decision-maker should also have a copy.

All copies of the POLST are valid, including digital (e.g., a picture of your POLST on your phone.)

LEARN MORE AT AKPOLST.ORG