



## CARE PLAN REVIEW DOCUMENTATION

**Patient/Resident Preferences/Documents on File**

**I have given significant thought to life-sustaining treatment. I expressed my preferences to my physician and/or health care provider(s). The following have further information regarding my preferences:**

|                          |                             |   |
|--------------------------|-----------------------------|---|
| Court-appointed Guardian | <input type="checkbox"/> NO | <input type="checkbox"/> YES – Attach copy of documentation |
| DPAHC                    | <input type="checkbox"/> NO | <input type="checkbox"/> YES – Attach copy                  |
| Living Will              | <input type="checkbox"/> NO | <input type="checkbox"/> YES – Attach copy                  |
| Other: _____             | <input type="checkbox"/> NO | <input type="checkbox"/> YES – Attach copy                  |

**Please review these orders at all care planning conferences or if there is a substantial change in my health status such as:**

|                         |                    |                              |
|-------------------------|--------------------|------------------------------|
| Close to death          | Improved condition | Advanced progressive illness |
| Extraordinary suffering |                    | Permanent unconsciousness    |

**Signature of Patient/Resident or Guardian/Health Care Agent**

**Agent Phone Number**

**Day:**

**Eve:**

|   |                              |                      |
|---|------------------------------|----------------------|
| <b>Signature of person preparing Form</b> | <b>Preparer Name (print)</b> | <b>Date Prepared</b> |
|---|------------------------------|----------------------|

**Review of this POLST Form**

| <b>Date of Review</b> | <b>Reviewer</b> | <b>Reason for Review</b> | <b>Out come of Review</b>  |
|-----------------------|-----------------|--------------------------|--|
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> FORM VOIDED, no new form        |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> FORM VOIDED, no new form        |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> FORM VOIDED, no new form        |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> <b>FORM VOIDED, no new form</b> |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> <b>FORM VOIDED, no new form</b> |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> <b>FORM VOIDED, no new form</b> |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> FORM VOIDED, no new form        |
|                       |                 |                          | <input type="checkbox"/> No Change<br><input type="checkbox"/> FORM VOIDED, new form completed<br><input type="checkbox"/> FORM VOIDED, no new form        |

**ORIGINAL FORM SHOULD ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**