MEDICAL ASSESSMENT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

NOTE TO LICENSED MEDICAL PROFESSIONAL: The person/patient named below is either a prospective resident or resident of a Residential Care Facility for the Elderly (RCFE) licensed by the Department of Social Services. The licensee is required to provide primarily non-medical care and supervision to meet the needs of that person/patient. The information that you provide about this person/patient is required by law to assist in determining whether the person/patient is appropriate for care in this non-medical facility [California Code of Regulations (CCR), Title 22, Section 87458, Medical Assessment]. THESE FACILITIES CANNOT PROVIDE SKILLED NURSING CARE.

This form is provided as a courtesy to prospective residents/residents and licensees.

(Please attach separate pages if needed.)

I. FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY/FACILITY CONTACT PERSON	PHONE NUMBER	E-MAIL ADDRESS
ADDRESS	CITY	ZIP CODE

II. PROSPECTIVE RESIDENT/RESIDENT INFORMATION (To be completed by the prospective resident/ resident or prospective resident's/resident's legal representative)

NAME	DATE OF BIRTH	AGE
ADDRESS	CITY	ZIP CODE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by prospective resident/resident or prospective resident's/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

I acknowledge that by providing my electronic signature for this form, I agree my electronic signature is the legal binding equivalent to my handwritten signature. I hereby confirm that my electronic signature represents my execution of authentication of this form, and my intent to be bound by it.

SIGNATURE OF PROSPECTIVE RESIDENT/RESIDENT OR PROSPECTIVE RESIDENT'S/RESIDENT'S LEGAL REPRESENTATIVE	DATE

IV. PROSPECTIVE RESIDENT/RESIDENT INFORMATION
(To be completed by the licensed medical professional)

DATE OF EXAM	GENDER	HEIGHT	WEIGHT	BLOOD PRESSURE

DIAGNOSIS/DIAGNOSES

a. Please indicate the prospective resident's/resident's diagnosis/diagnoses:

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

DEFINITIONS

Mild Cognitive Impairment (MCI): Refers to cognitive abilities that are in a "conditional state" between normal aging and dementia.

Major Neurocognitive Disorder (major NCD): Refers to substantially decreased cognitive or mental function due to a medical disease other than a psychiatric illness. Major NCD includes Alzheimer's disease and related disorders diagnosed by a licensed medical professional acting within their scope of practice. Related disorders considered to be major NCDs include, but are not limited to, vascular dementia, Lewy body dementia, Parkinson's disease, and frontotemporal dementia. Major NCDs cause impairment that is sufficient enough to interfere with independence in daily activities and may result in changes that include, but are not limited to, increased tendency to wander and decreased hazard awareness and ability to communicate.

COGNITIVE CONDITIONS

a. Does prospective resident/resident have any cognitive conditions? ☐ Yes ☐ No

If yes, please indicate cognitive condition(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

RESULTS OF EXAM FOR COMMUNICABLE TUBERCULOSIS (TB)

DATE TB TEST GIVEN	DATE TB TEST READ	TYPE OF TB TEST	RESULTS OF TB TEST

Action taken (if positive):

RESULTS OF EXAM FOR INFECTIOUS DISEASES

a. Does prospective resident/resident have any infectious diseases? ☐ Yes ☐ No

If yes, please indicate infectious disease(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

RESULTS OF EXAM FOR CONTAGIOUS DISEASES

a. Does prospective resident/resident have any contagious diseases? ☐ Yes ☐ No

If yes, please indicate contagious disease(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

RESULTS OF EXAM FOR OTHER MEDICAL CONDITIONS

a. Does prospective resident/resident have any other medical conditions? ☐ Yes ☐ No

If yes, please indicate other medical condition(s): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

ALLERGIES

a. Does prospective resident/resident have any allergies (e.g., seasonal, food, medication, dander)?
☐ Yes ☐ No

If yes, please indicate allergy(ies): _____

b. Treatment/medication (type and dosage)/equipment:

c. Can prospective resident/resident manage own treatment/medication/equipment? ☐ Yes ☐ No

If no, describe what assistance is needed:

1. OVERALL PHYSICAL HEALTH ☐ GOOD ☐ FAIR ☐ POOR

PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Hearing Loss	◯	◯		
b. Vision Loss	◯	◯		
c. Wears Dentures	◯	◯		
d. Wears Prosthesis	◯	◯		
e. Special Diet	◯	◯		
f. Substance Abuse	◯	◯		
g. Use of Alcohol	◯	◯		
h. Use of Nicotine or Related Products	◯	◯		
i. Bowel Incontinence	◯	◯		
j. Bladder Incontinence	◯	◯		
k. Motor Impairment/Paralysis	◯	◯		
l. Requires Assistance with Repositioning and Transferring	◯	◯		
m. History of Skin Condition or Breakdown	◯	◯		

COMMENTS:

2. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self	◯	◯	
b. Able to Dress/Groom Self	◯	◯	
c. Able to Feed Self	◯	◯	
d. Able to Care for Own Toileting Needs	◯	◯	
e. Able to Manage Own Cash Resources	◯	◯	
f. Able to Communicate	◯	◯	
g. Able to Follow Directions/ Instructions	◯	◯	
h. Able to Leave Facility Unsupervised (considering cognitive abilities); if no, please explain.	◯	◯	

COMMENTS:

3. OVERALL MENTAL HEALTH ◯ **GOOD** ◯ **FAIR** ◯ **POOR**

MENTAL HEALTH STATUS	YES	NO	EXPLAIN
a. Depressed	◯	◯	
b. Suicidal Ideation	◯	◯	
c. Self-Abuse	◯	◯	
d. Other	◯	◯	

COMMENTS:

4. BEHAVIORAL EXPRESSIONS*	YES	NO	EXPLAIN
a. Disorientation	◯	◯	
b. Lack of Hazard Awareness	◯	◯	
c. Lack of Impulse Control	◯	◯	
d. Unsafe Wandering**	◯	◯	
e. Elopement***	◯	◯	
f. Expressions of Frustration	◯	◯	
g. Hallucinations	◯	◯	
h. Other	◯	◯	

* "Behavioral expression" means behavior or behaviors displayed by a resident that may result in harm to self or others including, but not limited to, unsafe wandering, or elopement, expressions of frustration, disorientation, hallucinations, or lacking in hazard awareness or impulse control. Behavioral expression may be due to boredom, fear, overstimulation, perceived threat, fatigue, physical discomfort, pain, "Major Neurocognitive Disorder (major NCD)", or other causes including, but not limited to, medication interactions and/or illnesses such as urinary tract infections.

** "Unsafe wandering" occurs when a resident at risk enters an area that is physically hazardous or contains items that are potential safety hazards. For example, unsafe wandering may occur when a resident enters another resident's room when doing so may lead to an altercation or contact with hazardous items.

***"Elopement" occurs when a resident who is at risk of harm due to their cognitive condition leaves the facility unsupervised, or while in the licensee's care, leaves another safe location unsupervised.

COMMENTS:

5. ACCESS TO ITEMS	YES	NO	EXPLAIN
Would the prospective resident's/ resident's or other resident's safety be at risk if the resident had access to the following items:	◯	◯	
a. Personal care and hygiene items	◯	◯	
b. Disinfectants, cleaning solutions, poisonous substances, knives, matches, tools, sharp objects, and other similar items which could pose a danger to residents.	◯	◯	
c. Nutritional supplements, vitamins, alcohol, cigarettes and other potentially toxic substances, such as certain plants, gardening supplies, and auto supplies.	◯	◯	
Does the prospective resident/resident require supervision by the licensee when in proximity to or when there is use of:	◯	◯	
a. Ranges, ovens, heaters, fireplaces, wood stoves, inserts, and other heating devices.	◯	◯	
b. Fishponds, wading pools, hot tubs, swimming pools, or similar large bodies of water.	◯	◯	
c. Birdbaths, fountains, or similar smaller decorative water features.	◯	◯	

COMMENTS:

6. MEDICATION MANAGEMENT	YES	NO	N/A	EXPLAIN
a. Able to Administer Own Prescription Medications	◯	◯	◯	
b. Able to Administer Own Injections	◯	◯	◯	
c. Able to Perform Own Glucose Testing	◯	◯	◯	
d. Able to Administer Own PRN Medications	◯	◯	◯	
e. Able to Administer Own Oxygen	◯	◯	◯	
f. Able to Store Own Medications	◯	◯	◯	

COMMENTS:

AMBULATORY STATUS:

a. 1. The prospective resident/resident is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this prospective resident/resident is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: The prospective resident/resident is unable to leave a building unassisted under emergency conditions. This includes, but is not limited to, a prospective resident/resident who depends upon mechanical aids such as crutches, walkers, and wheelchairs. It also includes a prospective resident/resident who is unable, or likely to be unable, to respond physically or mentally to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire or other dangers, and if unassisted, to take appropriate action relating to such danger.

Note: A prospective resident/resident who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a prospective resident/resident who requires assistance with turning or repositioning in bed.

b. If prospective resident/resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If a prospective resident/resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a prospective resident/resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)
2. _____ (estimated date illness or recovery is expected to end or when prospective resident/resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain:

e. Is prospective resident/resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: _____

COMMENTS:

V. LICENSED MEDICAL PROFESSIONAL INFORMATION

I acknowledge that by providing my electronic signature for this form, I agree my electronic signature is the legal binding equivalent to my handwritten signature. I hereby confirm that my electronic signature represents my execution of authentication of this form, and my intent to be bound by it.

LICENSED MEDICAL PROFESSIONAL NAME AND ADDRESS (PRINT)	
PHONE NUMBER	E-MAIL ADDRESS
LENGTH OF TIME YOU HAVE PROVIDED CARE TO PROSPECTIVE RESIDENT/RESIDENT	
LICENSED MEDICAL PROFESSIONAL SIGNATURE	DATE

This Form is from an Assisted Living Facility

Assisted Living is a non-medical setting

PRN AUTHORIZATION LETTER

RE: Patient's Name: _____

A Resident of: Lavender Hills Assisted Living Date: _____

To receive nonprescription and prescription PRN medications, state licensing requires that either:

1) Your patient be capable of determining his/her own need for the medication, or
2) For nonprescription medication only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or, clearly communicate the symptoms for a nonprescription medication (box 3, below) ***then you, the physician, must be contacted before the PRN medication can be given each and every time.*** Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications – and potentially avoid the need to contact you prior to each PRN medication dosing.

Thank you for your assistance.

Sincerely,

Jennifer Boss, Administrator

Please check ONLY ONE BOX that describes your patient's ability.

☐ My patient *can determine* and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.

☐ My patient *cannot determine* his/her own need for nonprescription PRN medications, *but can clearly communicate his/her symptoms* indicating a need for a nonprescription medication.

☐ My patient *cannot determine* his/her need for prescription and/or nonprescription PRN medication and cannot clearly communicate his/her symptoms indicating a need for a nonprescription PRN medication. **(Licensee must contact physician before each dose and at all times.)**

Physician's Signature: _____ Date: _____

Confidential Communication Policy:

The information contained herein is intended only for the recipient and is legally protected private information. If you received this information in error please destroy or return it to Lavender Hills Assisted Living and contact our offices to report the error.

Lavender Hills Assisted Living LLC

License #455002027 #455002615

OVER THE COUNTER MEDICATIONS

Resident: **Physician:**

Please mark a line through any medications(s) you do NOT want given. Instructions and labels will be complied within the maximum dose allowed in a period of time:

Drug Name & Dosage:	Usage:	PRN Dosage:	NOT TO EXCEED:
Acetaminophen 325mg	Fever, headache or minor pain	325mg 1-2 tabs every 4 hours	3,000mg/24 hours
Acetaminophen 500mg	Fever, headache or minor pain	500mg 1-2 tabs every 4-6 hours	3,000mg/24 hours
Aleve 220mg	Pain reliever/fever reducer	220mg capsule 1 every 8-12 hours	3 tabs/24 hours
Ibuprofen 200mg	Pain reliever/fever reducer	200mg 1 tab every 4-6 hours	6 tabs/24 hours
Mucinex 600mg or 1200mg	Congestion/cough	600mg 1-2 tabs every 12 hours 1200mg 1 tab every 12 hours	2400mg/24 hours
Milk of Magnesia 1200mg	Constipation	30ml 2x daily w/ 8oz hot water	120ml/24 hours or 4 doses
Antacid (Generic Mylanta)	Upset Stomach	2tsp by mouth after meals & at bedtime	18tsp/24 hours
Metamucil	Occasional constipation	1 tbs in 8oz of liquid up to 3x	3tbs/24 hours
Pepto Bismol 262mg or 525mg	As directed on the bottle	2 tbs or tab q hour for diarrhea	6 doses/24 hours
Kaopectate 262mg	diarrhea/upset stomach	30ml: may repeat in ½ to 1 hour	8 doses/24 hours
Docusate Sodium	Stool softener/constipation	1-3 soft gels daily	3/24 hours
Senna or Senna S	Constipation	1-3 Tablets daily	8/24hrs
Muscle Rub (Bengay)	Sore muscles	Apply to sore area as needed	4X/daily
Robitussin/Guiatuss (Cough)	Cough Suppressant	2 tsps every 4 hours	6 doses/24 hours
Desitin/Barrier Cream	Minor rash or skin irritation	Apply as often as necessary	No Max listed
Cough Drops	Cough or Sore Throat	1 hour as needed	q hour: 1 week at a time
Vicks Vapor Rub	Congestion	Apply up 3x daily a thick layer w/loose clothing for vapors to reach nose	3x/24 hours
Imodium AD 2mg	Diarrhea	2 tabs after 1st loose stool and 1 tab each thereafter	4tabs/24 hours or 2 days usage
Tums 500mg or 1000mg	Heartburn, upset stomach, or indigestion	1-2 by mouth every hour	10 tabs/24 hours/2 weeks at a time
Benadryl 25mg	Allergies, allergic reactions, sleep aid	1 every 4 hours	6/24 hours
Nyquil	Flu/cold symptoms	2 tbs every 6 hours	4 doses/24 hours: 1 week at a time
Dayquil	Flu/cold symptoms	30ml every 4 hours	4/doses/24 hours
Sudafed	Allergies	30mg 2 tabs every 6 hours	8/24 hours
Ensure/Glucerna	Nutritional Supplement	1 – drink up to 3x daily	3 drinks/24 hours
Generic Eye Drops	Dry, itchy, red eyes	1 drop in each eye up to 4x	4 drops per eye/24 hours
Neosporin/Triple Antibiotic Ointment	Minor cuts & abrasions	Apply up to 3x daily	3x daily: 1 week at a time
Hydrocortisone Cream	For itching/skin irritation	Apply 3-4 times daily	4x daily for 7 days
Miralax 3350mg	Occasional Constipation	17 gm once daily	1 dose per day for 7 days
Alcoholic Beverage	Social Gatherings	1-2 drinks in 24 hours	As requested with dinner or at social gatherings
Postural Support- Bed Rail	As needed on bed for mobility	N/A	N/A

Physician's Signature: _____ Date: _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A — CARDIOPULMONARY RESUSCITATION (CPR):

Check One

If patient has no pulse and is not breathing.
If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS:

Check One

If patient is found with a pulse and/or is breathing.

☐ **Full Treatment - primary goal of prolonging life by all medically effective means.**

In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment - goal of treating medical conditions while avoiding burdensome measures.**

In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment - primary goal of maximizing comfort.**

Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatments unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION:

Check One

Offer food by mouth if feasible and desired.

☐ Long-term artificial nutrition, including feeding tubes.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available
☐ No Advance Directive

Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship (write self if patient)
Signature: (required)	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name (if other than signing Physician/NP/PA)**	
Name:	Name/Title:	Phone #

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by the physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit: www.capolst.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED