Name:_____ DOB:_____

Advance Directive/Tuberculosis Assessment/STI.

Advance Directive

1.	You have an advance directive:	Yes	No
2.	Will you like to discuss about advanced directive:	Yes	No
3.	Do you have a POLST	Yes	No
4.	Will you like to discuss	Yes	No

Tuberculosis Assessment

1.	Have you traveled outside the USA	Yes	No
2.	If Yes, where		
3.	Have you been exposed to someone with tuberculosis	Yes	No
4.	Have you had abnormal cough, night sweats or weight loss	Yes	No

STI Assessment

1.	Are you sexually active	Yes	No
2.	If yes, any new sexual partner	Yes	No
3.	Will you like to be tested for STI	Yes	No

Reviewed by:

Advance Directives: What You Need to Know

What Is An Advance Directive?

- An Advance Directive is a document that states in writing your wishes about what type of care you would want or do not want, in case you get hurt, sick or become unable to make medical decisions for yourself.
- On the form, you may choose an adult relative, spouse, partner or friend as your "agent" to make these decisions when the time comes.
- You must sign your name and write the date on the form.

Where Do I Begin?

- You can write or fill out your own advance directive if you are 18 years or older, and are able to make your own decisions.
- You do not need a lawyer to fill out the document, but it must be signed by a notary public or by 2 witnesses. Your "agent" cannot be one of the witnesses.

Choose A Person You Trust.

- After you choose this person, talk to them in detail about what you want. Make sure this person knows your wishes and are willing to make them for you.
- Talk with your doctor and "agent" about what you want and give them both a copy.
- Your doctor may ask you to sign a form that states you have talked to them about this document.

Can I Change My Mind?

- You may change or cancel your advance directive at any time, as long as you are aware of how the choices impact your health care. Being aware means you can still think and voice your wishes in a clear manner. You can also change your "agent."
- Make sure that your doctor and your "agent" know about any changes.

Why Sign One Now When I'm Healthy?

- The best time to sign an advance directive is when you are healthy, and are able to think and speak for yourself. Having a plan in place will ensure that your wishes are followed.

Where Can I Get The Advance Directive Document?

- Most hospital emergency rooms and the Orange County Office on Aging have these forms. Call **1-800-510-2020** for more information. You do not need to use a form. You can also write your wishes down on paper and have this document signed instead.
- Contact Caring Connections at **www.caringinfo.org**.

CalOptima Health

Patients Name:

Date of Birth:

Patients phone number:

ADVANCED DIRECTIVE ACKNOWLEGMENET

_____ I **do have** an Advanced Directive/ Living Will / Durable Power of Attorney for medical or health care decisions.

_____ I **do not have** an Advanced Directive/ Living Will / Durable Power of Attorney for medical or health care decisions.

_____ I **would like** further information on Advanced Directives.

_____ I **would not like** further information on Advanced Directives

Patients Signature _____ Date _____

Physical or Office Staff please complete:

_____ Information regarding Advanced Directives **was provided**.

_____ Information regarding Advanced Directives **was not provided**.

If Information was provided, what type? _____ Verbal _____ Written

If the member has an Advanced Directive, has it been placed in the Medical Record:

_____ Yes _____ No

Comment:

Physician or Staff 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 4/1/2017)*

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): *If patient has no pulse and is not breathing*

Check One

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

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

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C

B MEDICAL INTERVENTIONS: *If patient is breathing with a pulse*

Check One

☐ **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 Treatment 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: *Offer by mouth if feasible and desired*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

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 Name: _____
☐ No Advance Directive 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:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
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, 4/1/2011,10/1/2014 or 01/01/2016 are also valid