



## AGENDA

### CONTRA COSTA COUNTY Advisory Council on Aging

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**Monday, May 11, 2026**

**1:00 PM**

**500 Ellinwood Way, Pleasant Hill, CA.  
Corner Conference Room**

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**Health and Elder Abuse Prevention Committee**  
**<https://cccounty-us.zoom.us/j/83870526995>**

The public may attend this meeting in person at the above location. The public may also attend this meeting remotely via webinar. Login information is provided above. The public may attend this meeting in person at the above location. ACOA members will also be participating from the following locations: 2950 Buskirk Avenue. Suite 330 Walnut Creek | 400 El Cerro Blvd., Danville | 311 Calle la Mesa, Moraga | 233 Gregory Lane, Pleasant Hill

1:00 Open meeting: Dr. Mike Wener, Chairman

Roll call (Dixie Peralta)

1:05 Approve April 2026 Minutes

Health Committee Meeting Minutes 04-13-26

[26-1896](#)

1:10 Member Reports:

- Nutrition
- Elder Wellness & Advocacy Coalition- Carol
- Medi-Cal- Brian

1:25 Presentation- Dr. Mike Wener, Advance Health Directives forms and Physician Orders for Life-Sustaining Treatment (POLST)

Advance Health Care Directive Form | Physician Orders for Life Sustaining Treatment (POLST)

[26-1897](#)

1:55 Break

2:00 Nutrition Report- Discuss whether to continue to keep as part of member reports

2:15 Community Presentations –

- Tracking

Next Health & Elder Abuse Prevention Committee Meeting: -

Wednesday, June 8, 2026 1:00pm – 2:30pm

2:30 Adjourn

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 500 Ellinwood Way, Pleasant Hill during normal business hours. Staff reports related to items on the agenda are also accessible online at [www.contracosta.ca.gov](http://www.contracosta.ca.gov). If the Zoom connection malfunctions for any reason, the meeting may be paused while a fix is attempted. If the connection is not reestablished, the committee will continue the meeting in person without remote access. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:

Cristina Ugaitafa at 925 655-0775 or [cugaitafa@ehsd.cccounty.us](mailto:cugaitafa@ehsd.cccounty.us)



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1896

**Agenda Date:** 5/11/2026

**Agenda #:**

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### Advisory Council on Aging:

Health and Elder Abuse Prevention Committee Meeting Minutes 04-13-2026



# CONTRA COSTA COUNTY

## Committee Meeting Minutes - Draft

### Advisory Council on Aging

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Monday, April 13, 2026

1:00 PM

500 Ellinwood Way, Pleasant Hill, CA.  
Corner Conference Room

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Health and Elder Abuse Prevention Committee  
<https://cccouny-us.zoom.us/j/83870526995>

The public may attend this meeting in person at the above location. The public may also attend this meeting remotely via webinar. Login information is provided above. ACOA members will also be participating from the following locations: 2950 Buskirk Avenue, Suite 330 Walnut Creek | 400 El Cerro Blvd., Danville | 111 Civic Drive, Hercules | 366 Caroni St., Walnut Creek | 130 Linhares Lane, Alamo

1:00 Open meeting: Dr. Mike Wener, Chairman  
- Call to Order: The meeting was called to order at 1:03 pm.

Roll call (Dixie Peralta)  
Adopt Today's Agenda

**Present** Holly Frates, Sarah Green, Thomas Lang, Sharon Maxwell, Brian O'Toole, Carol Schaefer, Teresa Wright, Michael Wener, Dennis Yee, and Deborah Wiener

**Absent** Alan Goldhammer, Nikki Lopez, Terri Tobey, and Susan Wright

1:05 Approve March 2026 Minutes

**Motion:** Lang

**Second:** Yee

**Aye:** Frates, Lang, Maxwell, O'Toole, Schaefer, Wright, Wener, Yee, and Wiener

**Absent:** Goldhammer, Lopez, Tobey, and Wright

**Abstain:** Green

**Result:** Passed

Health Committee Meeting Minutes 03.09.26

[26-1427](#)

## 1:10 Member Reports:

- Nutrition- No report
  
- Elder Wellness & Advocacy Coalition- Carol
  - Meetings are held on the 2nd Wednesday of the month, 2:00-3:30 pm
  - Presentation from Director of Housing Authority, Tony Ucciferri, Deputy Executive Director, Contra Costa Housing Authority, “Housing Programs Overview”
  - There was no meeting in April, so there will be no report for the May meeting
  - Kevin to ask Logan Roberston at ACOA meeting whether vouchers can be used for shared housing and will follow up with Mike
  
- Medi-Cal- Brian- Brian on updates to Medi-Cal
  - No new developments
  - Gave presentation to Choice in Aging (to caregivers) and the Planning Committee for updates and to discuss whether presentations can be scheduled in the community

## 1:25 Presentation- Mary Blumberg, Deputy District Attorney, Elder Abuse Unit Supervisor

- Mary Blumberg, Deputy District Attorney, Elder Abuse Unit Supervisor, presented on what is being seen in Contra Costa County related to elder abuse (physical, financial abuse)
  - Elder Abuse Prevention Partnership
  - A future presentation can be from the Federal Government on elder financial abuse (financial abuse where money is going overseas)
- APS MDT Meetings and FAST meetings
  - Mary to send information to Mike about the meetings to be shared with Committee members

## 1:55 Break

## 2:00 MPA California Master Plan on Aging Goal 2: Health Reimagined

- Cristina reviewed what’s available for Goal 2 on the MPA at Master Plan for Aging <https://mpa.aging.ca.gov/Goals/2/>

## 2:15 Community Presentations

- Thomas developed spreadsheets to track presentations- list of who is presenting, when they're presenting, organizations, conflicts of interest
- Spreadsheets were added to the agenda for this meeting
  - Thomas presented the attachments including 1) Invited Speakers to the committee and 2) Senior Center List
    - Invited speakers
      - The spreadsheet can be used to help vet speakers
      - Thomas stated he can go back to fill out the spreadsheet for the past speakers
      - Kevin would like for the invited speakers spreadsheet to go to Exec to standardize presentations
      - Can be used as a reference to bring back speakers in the future
    - Senior Centers list
      - To be used for tracking presentations, for internal ACOA members, or for those outside of ACOA, that would be invited by the committee to present in the community
      - Includes contract information for senior centers for those that would like to schedule presentations
- Cristina shared the scheduled presentations for the year that will take place for future committee meetings
  - May- Richard Leiblich on Reduction, Streamlining, and Optimization of Medications
  - June- Mike Wener, diabetic foot, including evaluation and treatment (The presentation on Advance Care Directives so this would be in a different month)
  - July- no meeting
  - August- Thomas Weisbrich, OAA Nutrition Programs
  - September- Kim Colon, Vestibular Disorders- treatment and symptoms causing vertigo, dizziness, imbalance, and nausea especially in older adults
  - October- Sarah, TBD
  - November- no meeting
  - December- Thomas Lang, sarcopenia

Invited Speaker (tracking) | Senior Center List

[26-1428](#)

## 2:20 Discussion:

- Thomas will present on Sarcopenia at Good Table Café, in El Sobrante, at 4:30 pm, on Monday, April 21st, with Dr. Bailey (John Muir)
- Thomas to email flyer to ACOA members
- Kevin would like the presentation offered in Danville

## 2:25 Public Comment

- Sarah- sales tax measure
  - attended wellness fair on March 31st, at Hercules Senior Center
  - Tabled with Park and Rec and shared information to advocate for County's sales tax measure
- Jim- sales tax measure offsetting the impacts on HR1 on EHSD budget

Next Health & Elder Abuse Prevention Committee Meeting:  
- Wednesday, May 11, 2026 1:00pm – 2:30pm

2:30 Adjourn  
- Meeting adjourned at 2:40 pm

For Additional Information Contact:  
Cristina Ugaitafa at 925 655-0775 or [cugaitafa@ehsd.cccounty.us](mailto:cugaitafa@ehsd.cccounty.us)

DRAFT



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1897

**Agenda Date:** 6/11/2026

**Agenda #:**

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### Advisory Council on Aging:

- Advance Health Care Directive Form
- What is Physician Orders for Life Sustaining Treatment (POLST)

# ADVANCE HEALTH CARE DIRECTIVE FORM

Probate Code - PROB

DIVISION 4.7. HEALTH CARE DECISIONS [4600 - 4806] ( Division 4.7 added by Stats. 1999, Ch. 658, Sec. 39. )

PART 2. UNIFORM HEALTH CARE DECISIONS ACT [4670 - 4743] ( Part 2 added by Stats. 1999, Ch. 658, Sec. 39. )

CHAPTER 2. Advance Health Care Directive Forms [4700 - 4701] ( Chapter 2 added by Stats. 1999, Ch. 658, Sec. 39. )

4701. The statutory advance health care directive form is as follows:

## ADVANCE HEALTH CARE DIRECTIVE (California Probate Code Section 4701) Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Donate your organs, tissues, and parts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues, and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1  
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

**ADVANCE HEALTH CARE DIRECTIVE FORM**

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

:

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(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

**PART 2  
INSTRUCTIONS FOR HEALTH CARE**

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

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(Add additional sheets if needed.)

PART 3  
DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH  
(OPTIONAL)

(3.1)  Upon my death, I give my organs, tissues, and parts (mark box to indicate yes).  
By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (strike any of the following you do not want):

- (a) Transplant
- (b) Therapy
- (c) Research
- (d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

\_\_\_\_\_

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4  
PRIMARY PHYSICIAN  
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address) (city) (state) (ZIP Code)

\_\_\_\_\_  
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address) (city) (state) (ZIP Code)

\_\_\_\_\_  
(phone)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

\_\_\_\_\_  
(date) (sign your name)

\_\_\_\_\_  
(address) (print your name)

\_\_\_\_\_  
(city) (state)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness

Second witness

\_\_\_\_\_  
(print name) (print name)

\_\_\_\_\_  
(address) (address)

\_\_\_\_\_  
(city) (state) (city) (state)

\_\_\_\_\_  
(signature of witness) (signature of witness)

\_\_\_\_\_  
(date) (date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

\_\_\_\_\_  
(signature of witness) (signature of witness)

PART 6  
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(sign your name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(city) (state)

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California,  
County of \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_  
(insert name and title of officer)

personally appeared \_\_\_\_\_

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person (s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (SEAL)

## What is a POLST?

### *Key Facts About POLST for Individuals and Family Members*

*Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.*

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.
- **POLST is for people who are seriously ill or have advanced frailty.** If you are healthy, an advance directive is for you.
- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.
- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.
- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) AND your physician, nurse practitioner, or physician assistant.**
- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST.** Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.
- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.
- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.
- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: <http://www.capolst.org/> or call (916) 489-2222 for more information.



EMSA #111 B  
(Effective 4/1/2017)\*

# Physician Orders for Life-Sustaining Treatment (POLST)

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

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)

**B** **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

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 food 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:
Mailing Address (street/city/state/zip):	Phone Number:

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

**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

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

## Patient Information

Name (last, first, middle):	Date of Birth:	Gender: <b>M</b> <b>F</b>
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## NP/PA's Supervising Physician

Name:	<b>Preparer Name</b> (if other than signing Physician/NP/PA) Name/Title:	Phone #:
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## Additional Contact

None

Name:	Relationship to Patient:	Phone #:
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## 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 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](http://www.caPOLST.org).

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**