

COVID-19

ADDENDUM TO THE POLST

NAME: _____

DATE _____

I, _____, have a POLST in place stating my wishes for medical care, my options have been explained to me, as to what level of care I wish to have in the event I contract COVID-19.

I have decided the following:

- _____ A. My current POLST that I have in place is to remain in effect during the COVID-19 pandemic (state what is in place on the POLST) _____
- _____ B. I wish to change my code status to full code and full treatment. Complete a new POLST form.
- _____ C. I wish to continue for my code status to be a DNR and I wish to change the level of treatment I would receive in the event of contracting COVID-19 to:
 - Full Treatment
 - Selective Treatment
 - Comfort Measures (provided in the nursing home)

Signature _____ (Resident)

Signature _____ (Resident representative)

Signature _____ (Witness)

Notified physician _____

Modify physician orders _____