



### **Frequently Asked Questions:**

While most Americans believe that death comes suddenly at the end of a productive and full life, this is not usually the case. Death comes suddenly and without warning to less than 20 percent of people. The other 80 percent of the time, progressive illness, debility and death comes after a period that may range from weeks to years. Having discussions regarding available options for treatment is a great way to involve patients and families in the decisions regarding health care.

Studies have shown that patients and families who discuss what is occurring and how to best to plan for the future actually get better patient-centered medical care in the place that they want it, whether it's at home, Assisted Living Facility, Nursing Home, ER or hospital.

An AR POLST form provides for an easily identifiable document that translates a patient's end-of-life wishes and goals of care into a physician's order that transfers with the patient wherever they go in the health care system. This allows communication among all health care professionals in real time with the patient at the center.

The AR POLST form is:

- A model program for end-of-life care
- A best practice model using evidence-based medicine
- Transferable along health care settings
- Complementary with advance directives/living wills
- Voluntary
- Not biased for or against any specific treatment

An AR POLST form may be revoked/voided at any time by the patient or legal representative.