

# Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Last Name/First/Middle Initial		
Address		
City/State/Zip		
Date of Birth (mm/dd/yyyy) ____/____/____	Last 4 SSN □□□□	Gender <input type="checkbox"/> M <input type="checkbox"/> F

<b>Section A</b> Check One Box Only	<b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse <u>and</u> is not breathing.</b> <input type="checkbox"/> <b>Resuscitate (CPR)</b> <input type="checkbox"/> <b>Do Not Attempt Resuscitation (DNR/no CPR)</b> When not in cardiopulmonary arrest, follow orders in B, C, and D.
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<b>Section B</b> Check One Box Only	<b>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</b> <input type="checkbox"/> <b>Comfort Measures</b> Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Do not transfer to hospital for life-sustaining treatment. Transfer <u>only</u> if comfort needs cannot be met in current location.</b> <input type="checkbox"/> <b>Limited Additional Interventions</b> Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <b>Transfer to hospital if indicated. Avoid intensive care.</b> <input type="checkbox"/> <b>Full Treatment</b> Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <b>Transfer to hospital if indicated. Include intensive care.</b> Other Instructions: _____
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<b>Section C</b> Check One Box Only	<b>ANTIBIOTICS</b> <input type="checkbox"/> <b>No Antibiotics</b> <input type="checkbox"/> <b>Antibiotics</b> Other Instructions: _____
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<b>Section D</b> Check One Box Only in Each Column	<b>Medically Administered Fluids and Nutrition:</b> Oral fluids and nutrition must be offered if medically feasible.	
	<input type="checkbox"/> <b>No IV fluids</b> (provide other measures to assure comfort) <input type="checkbox"/> <b>IV fluids for a defined trial period</b> <input type="checkbox"/> <b>IV fluids long-term if indicated</b> Other Instructions: _____	<input type="checkbox"/> <b>No feeding tube</b> <input type="checkbox"/> <b>Feeding tube for a defined trial period</b> <input type="checkbox"/> <b>Feeding tube long-term</b>

<b>Section E</b>	<b>Discussed with:</b> <input type="checkbox"/> Patient/Resident <input type="checkbox"/> MPOA representative <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Spouse <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Other: _____ (Specify)	<b>The Basis for These Orders Is:</b> (Must be completed) <input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient's preferences unknown) <input type="checkbox"/> (Other) _____
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Physician Name (Print)	Physician Phone Number	Office Use Only
Physician Signature (Mandatory)	Date	

**FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**

**Review of POST**

Last Name/First/Middle Initial

This form should be reviewed if there is substantial change in patient/resident health status, or patient/resident treatment preferences change. According to state law, the form must be reviewed if the patient/resident is transferred from one health care setting to another.

If this form is to be voided, write the word "VOID" in large letters on the front of the form. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

<b>Section F</b>	<b>Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form</b>			
	Advance Directive (Living Will or MPOA)*	<input type="checkbox"/> NO	<input type="checkbox"/> YES	- Attach copy
Organ and Tissue Document of Gift	<input type="checkbox"/> NO	<input type="checkbox"/> YES	- Attach copy of documentation	
Court-appointed Guardian*	<input type="checkbox"/> NO	<input type="checkbox"/> YES	- Attach copy of documentation	
Health Care Surrogate Selection*	<input type="checkbox"/> NO	<input type="checkbox"/> YES	- Attach copy of documentation	
*Contact Name: _____		Phone: _____		
<input type="checkbox"/> If I lose decision-making capacity, I authorize my medical power of attorney representative/health care surrogate to make all medical decisions for me, including those regarding CPR and other life-sustaining treatment and to complete a new form <b>(Initials in box indicate patient acceptance of this statement).</b>				

**Opt In**  **Initial box if you agree to have your POST form, do not resuscitate card, living will and medical power of attorney form (if completed) submitted to the WV eDirective Electronic Registry and released to treating health care providers.**

Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)		Date
Signature of Person Preparing Form	Preparer Name (Print)	Date Prepared

<b>Section G</b>	<b>Review of this POST Form</b>				
	<b>Date of Review</b>	<b>Reviewer</b>	<b>Physician Signature</b>	<b>Location of Review</b>	<b>Outcome of Review</b>
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form

**FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**

**DO NOT ALTER THIS FORM !**