FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

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 Name/Middle Initial

Date of Birth

Section A
Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.

Section B
Check One Box Only

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures** 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. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Full Treatment** Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

Other Instructions: _____

Section C
Check One Box Only

ANTIBIOTICS

☐ **No Antibiotics**

☐ **Antibiotics**

Other Instructions: _____

Section D
Check One Box Only in Each Column

Medically Administered Fluids and Nutrition: Oral fluids and nutrition must be offered if medically feasible.

☐ **No IV fluids** (provide other measures to assure comfort)
☐ **IV fluids for a defined trial period**
☐ **IV fluids long-term if indicated**

☐ **No feeding tube**
☐ **Feeding tube for a defined trial period**
☐ **Feeding tube long-term**

Other Instructions: _____

Section E

Discussed with:
☐ Patient/Resident
☐ MPOA representative
☐ Court-appointed guardian
☐ Health care surrogate
☐ Spouse
☐ Parent of Minor
☐ Other:_____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient's preferences unknown)
☐ (Other) _____

Physician Name (Print)	**Physician Phone Number**	**Office Use Only**
Physician Signature (Mandatory)	**Date**	

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Review of POST

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.*

Section F

Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form

Advance Directive (Living Will or MPOA)*	☐ **NO**	☐ **YES** - Attach copy
Organ and Tissue Document of Gift	☐ **NO**	☐ **YES** - Attach copy of documentation
Court-appointed Guardian*	☐ **NO**	☐ **YES** - Attach copy of documentation
Health Care Surrogate Selection*	☐ **NO**	☐ **YES** - Attach copy of documentation

*Name: _____ Phone Contact: _____

☐ 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 **(Initials in box indicate patient acceptance of this statement).**

Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)

Signature of Person Preparing Form	**Preparer Name** (Print)	**Date Prepared**

Section G

Review of this POST Form

Date of Review	Reviewer	Physician Signature	Location of Review	Outcome of Review
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form

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DO NOT ALTER THIS FORM !