

<p align="center"><b>Physician Orders</b> for Scope of Treatment (POST)</p> <p>This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.</p>	<p>Patient's Last Name</p> <hr/> <p>First Name/Middle Initial</p> <hr/> <p>Date of Birth</p>
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<b>Section A</b>	<p><b>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.</b></p> <p><input type="checkbox"/> <b>Resuscitate (CPR)</b>                      <input type="checkbox"/> <b>Do Not Attempt Resuscitate (DNR/no CPR)</b></p> <p>When not in cardiopulmonary arrest, follow orders in B, C, and D.</p>
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<b>Section B</b>	<p><b>MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing.</b></p> <p><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></p> <p><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></p> <p><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></p> <p><i>Other Instructions:</i> _____</p>
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<b>Section C</b>	<p><b>ANTIBIOTICS – Treatment for new medical conditions:</b></p> <p><input type="checkbox"/> <b>No Antibiotics</b></p> <p><input type="checkbox"/> <b>Antibiotics</b></p> <p><i>Other Instructions:</i> _____</p>
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<b>Section D</b>	<p><b>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION.</b> Oral fluids and nutrition must be offered if medically feasible.</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> <b>No IV fluids</b> (provide other measures to assure comfort)</td> <td><input type="checkbox"/> <b>No feeding tube</b></td> </tr> <tr> <td><input type="checkbox"/> <b>IV fluids for a defined trial period</b></td> <td><input type="checkbox"/> <b>Feeding tube for a defined trial period</b></td> </tr> <tr> <td><input type="checkbox"/> <b>IV fluids long-term if indicated</b></td> <td><input type="checkbox"/> <b>Feeding tube long-term</b></td> </tr> </table> <p><i>Other Instructions:</i> _____</p>	<input type="checkbox"/> <b>No IV fluids</b> (provide other measures to assure comfort)	<input type="checkbox"/> <b>No feeding tube</b>	<input type="checkbox"/> <b>IV fluids for a defined trial period</b>	<input type="checkbox"/> <b>Feeding tube for a defined trial period</b>	<input type="checkbox"/> <b>IV fluids long-term if indicated</b>	<input type="checkbox"/> <b>Feeding tube long-term</b>
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<b>Section E</b>  <i>Must be Completed</i>	<p><b>Discussed with:</b></p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Health care agent</p> <p><input type="checkbox"/> Court-appointed guardian</p> <p><input type="checkbox"/> Health care surrogate</p> <p><input type="checkbox"/> Parent of minor</p> <p><input type="checkbox"/> Other: _____ (Specify)</p>	<p><b>The Basis for These Orders Is:</b> (Must be completed)</p> <p><input type="checkbox"/> Patient's preferences</p> <p><input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown)</p> <p><input type="checkbox"/> Medical indications</p> <p><input type="checkbox"/> (Other) _____</p>		
	<p><b>Physician Name (Print)</b></p>	<p><b>Physician Phone Number</b></p>		<b>Office Use Only</b>
	<p><b>Physician Signature (Mandatory)</b></p>	<p><b>Date</b></p>		

**HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Signature of Patient, Parent of Minor, or Guardian/Health Care Representative**

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)
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**Contact Information**

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

**Directions for Health Care Professionals**

**Completing POST**

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

**Using POST**

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

**Reviewing POST**

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

**COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.**

**DO NOT ALTER THIS FORM !**