

## Indiana Physician Orders for Scope of Treatment (POST)

First follow these orders. Contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated. Emergency Medical Services (EMS) contact Medical Control per protocol. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Patient Last Name:	Patient First Name	Middle Int.
Birth date: (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	Date prepared mm/dd/yyyy
Address: (street / city / state / zip)		

<b>A</b> <i>Check One</i>	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>Patient has no pulse AND is not breathing.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders in B and C and D

<b>B</b> <i>Check One</i>	<b>MEDICAL INTERVENTIONS:</b> <i>If patient has pulse AND is breathing OR has pulse and is NOT breathing.</i>
	<input type="checkbox"/> <b>Comfort Measures Only (Allow Natural Death).</b> Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital ONLY if comfort needs cannot be met in current location. Treatment Goal: Maximize comfort through symptom management.</b>  <input type="checkbox"/> <b>Limited Additional Interventions</b> In addition to care described in Comfort Measures Only, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. <b>Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible. Treatment Goal: Stabilization of medical condition.</b>  <input type="checkbox"/> <b>Full Treatment</b> In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. <b>Transfer to hospital and/or intensive care unit if indicated to meet medical needs. Treatment Goal: Full treatment including life support measures in the intensive care unit.</b> <b>Additional Orders:</b>

<b>C</b> <i>Check One</i>	<b>ANTIBIOTICS</b>
	<input type="checkbox"/> Use antibiotics for infection only if comfort cannot be achieved fully through other means <input type="checkbox"/> Use antibiotics consistent with treatment goals. <b>Additional Orders:</b>

<b>D</b> <i>Check One</i>	<b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food and fluid by mouth if feasible.</i>
	<input type="checkbox"/> No artificial nutrition. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____) <input type="checkbox"/> Long-term artificial nutrition. <b>Additional Orders:</b>

<b>E</b>	<b>DOCUMENTATION OF DISCUSSION:</b>
	<input type="checkbox"/> Patient (Patient has capacity) <input type="checkbox"/> Other /relationship _____ Orders discussed with <input type="checkbox"/> Physician <input type="checkbox"/> APN/PA _____
	<b>Signature of Patient or Surrogate</b> Signature: <u>required</u> Name (print):                      Relationship (write "self" if patient):

<b>F</b>	<b>SIGNATURE OF PHYSICIAN</b>
	My signature below indicates to the best of my knowledge that these orders are consistent with the patient's <b>current</b> medical condition and preferences.
	Print Signing Physician Name: <u>required</u> Physician office Phone Number:                      License Number:  Physician Signature: <u>required</u> Date: <u>required</u> Office Use Only

## Contact Information

Surrogate identified in section E (required if patient has no capacity)	Relationship:	Phone Number:	Address:
Health Care Professional Preparing Form (optional)		Phone Number:	Date Prepared:

The POST form is **always voluntary** and is usually for persons with advanced chronic progressive illness and/or frailty, or terminal illness. POST is based on your goals of care and records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An Advance Directive, including designation of a surrogate to speak on your behalf if you cannot speak for yourself is recommended for all capable adults, regardless of their health status.

## Directions for Health Care Professionals

### Completing POST

- Should reflect current preferences of persons with advanced chronic progressive illness and/or frailty.
- Verbal / phone orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes are also legal and valid.

### Using These *Medical Orders*

- A person with capacity or the valid surrogate of a person without capacity may revoke the POST orders at any time.
- Any section of these *Medical Orders* not completed implies full treatment for that section.
- Comfort care is never optional; Oral fluids and oral 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., management of hip fracture).
- Persons who are in need of emergency medical services due to a sudden accident or injury outside the scope of the person's illness should receive treatment to manage their medical needs.
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment" in section B on page one of this form.
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns with the patient or authorized surrogate and revise orders with consent of patient or surrogate.
- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility and provide appropriate care in the meantime.
- The authority of the named surrogate decision maker on this form is bound by Indiana statutes.
- In the event the patient is hospitalized, the admitting physician, after evaluating the patient and reviewing the POST form, may recommend new orders based on the patient's condition and the known desires of the individual or, if unknown, the individual's best interest.

### Reviewing POST

This POST should be reviewed periodically. Circumstances under which the form should be reviewed include but are not limited to,

- the patient is transferred from one care setting or care level to another,
- there is a substantial change in the patient's health status,
- the patient's treatment preferences change,
- the patient's primary care professional changes.

### Voiding POST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.