## Physician Orders for Scope Treatment (POST) 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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.



TDH, DHLR, Office of Health Care Facilities, 227 French Landing, Suite 501, Heritage Place Metrocenter, Nashville, TN 37243

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED						
Physician Orders for Scope of Treatment (POST)			Patient's Last Name			
This is a Physician Order Sheet based on the med and wishes of the person identified at right ("patient" not completed indicates full treatment for that section occurs, first follow these orders, then contact physicia		). Any section n. When need	First Name/Middl Date of Birth	le Initial		
Section						
A Check One Box	Ck       □       Resuscitate (CPR)       □       Do Not Attempt Resuscitation (DNR / no C Death)					
Only	When not in cardiopulmonary arrest, follow orders in <b>B, C,</b> and <b>D.</b>					
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/ <u>or</u> 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 <u>only</u> if comfort needs cannot be met in current location.					
Check One Box Only	<ul> <li>□ 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.</li> <li>Transfer to hospital if indicated. Avoid intensive care.</li> </ul>					
	☐ <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:					
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions:   No Antibiotics  Antibiotics  Other Instructions:					
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & 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  Other Instructions:					
Section E Must be Completed	Discussed with:  ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other:(Specify)	The Basis for These Orders Is: (Must be completed)  ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)				
Physician's	Name (Print) Physician's	s Signature (I	Mandatory)	Date	Physician's Phone Number	
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative  Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.						
Name (Print) Signar		ure	Relationship (write "self" if patient)			
Surrogate		Relationship		Phone Number (	)	
Health Care Professional Preparing Form		Preparer Title	)	Phone Number ( )	Date Prepared	

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

