



A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED			
Physician Orders for Scope of Treatment (POST) 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, first follow these orders, then contact physician.		Patient's Last Name	
		First Name/Middle Initial	
		Date of Birth	
Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing. <input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B, C, and D:		
Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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 – Treatment for new medical conditions: <input type="checkbox"/> No Antibiotics <input type="checkbox"/> 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. <input type="checkbox"/> No IV fluids (provide other measures to assure comfort) <input type="checkbox"/> No feeding tube <input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> IV fluids long-term if indicated <input type="checkbox"/> Feeding tube long-term Other Instructions: _____		
Section E Must be Completed	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Other: _____ (Specify)	The Basis for These Orders is: (Must be completed). <input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other) _____	
Physician's Name (Print)	Physician's Signature (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)	Signature	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