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, Division of Health Licensure and Regulation, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37243

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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 and/or is not breathing.

☐ **Resuscitate (CPR)** ☐ **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 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 – 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)	☐ **No feeding tube**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **IV fluids long-term if indicated**	☐ **Feeding tube long-term**

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 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

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