INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (6-13)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: Follow these orders first. Contact treating physician, advanced practice nurse, or physician assistant for further orders if indicated. Emergency Medical Services (EMS) should 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. HIPAA permits disclosure to health care professionals as necessary for treatment. Original form is personal property of the patient.

Patient Last Name	Patient First Name	Middle Initial

Birth date *(mm/dd/yyyy)*	Medical Record Number	Date prepared *(mm/dd/yyyy)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse AND is not breathing.*

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation (DNR)

When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**

B *Check One*

MEDICAL INTERVENTIONS: *If patient has pulse AND is breathing OR has pulse and is NOT breathing.*

☐ *Comfort Measures (Allow Natural Death)*: Treatment Goal: Maximize comfort through symptom management. 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. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ *Limited Additional Interventions*: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, 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. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ *Full Intervention*: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

E

DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:

☐ Patient (patient has capacity) ☐ Health Care Representative

☐ Legal Guardian / Parent of Minor ☐ Health Care Power of Attorney

SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE

My signature below indicates that my physician discussed with me the above orders and the selected orders correctly represent my wishes. If signature is other than patient's, add contact information for representative on reverse side.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F

SIGNATURE OF PHYSICIAN

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

Print Signing Physician Name ***(required by statute)***	Physician Office Telephone Number ***(required by statute)*** ( ) _____ – _____	License Number ***(required by statute)***

Physician Signature ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*	Office Use Only

The Indiana Physician Orders for Scope of Treatment (POST) form is always voluntary. POST is based on your goals of care and records your wishes for medical treatment. 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. No form can address all the medical treatment decisions that may need to be made. An Advance Directive, including appointing someone to speak on your behalf if you cannot speak for yourself, is recommended. You can identify a health care representative in the box below if you have not already done so. HIPAA permits disclosure to health care professionals as necessary for treatment.

Name of Health Care Representative	Telephone Number ( ) _____ - _____
Relationship to Patient	Address *(number and street, city, state, and ZIP code)*

I hereby appoint the above named person as my representative to act in my behalf on all matters concerning my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation above supersedes (replaces) any prior named Health Care Representative(s).

Patient Signature	Date *(mm/dd/yyyy)*	Witness (adult other than designated Health Care Representative)

Relationship of Representative identified in Section E if patient has no capacity ***(required by statute)***	Address	Telephone Number
Healthcare Professional Preparing Form if other than the person named in Section F	Preparer Title	Telephone Number

Completing Physician Orders for Scope of Treatment (POST)

- POST orders should reflect current treatment preferences of the patient.
- If the patient lacks capacity, the form may be completed by legally appointed guardian, healthcare representative, healthcare power of attorney, or parent of minor. The authority of the named Health Care Representative is bound by Indiana statutes.
- Verbal / telephone orders are acceptable with follow-up signature by physician in accordance with facility/community policy and state law.
- The POST form is the personal property of the patient. Use of original form is encouraged, however photocopies, electronic copies and faxes are also legal and valid.

Using Physician Orders for Scope of Treatment (POST)

- Persons who are in need of emergency medical services because of a sudden accident or injury outside the scope of the person's illness should receive treatment to manage their medical needs.
- Any section of these POST orders not completed implies full treatment for that section.
- Oral fluids and oral nutrition must always be offered if medically feasible.
- Comfort care is never optional. When comfort cannot be achieved in the current setting, the person, including someone designating "Comfort Measures," should be transferred to a setting able to provide comfort (e.g., hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has designated "Comfort Measures."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should select "Limited Additional Interventions" or "Full Intervention" in Section B of this form.
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns and revise orders with the consent of the patient or authorized representative.
- If a health care provider or facility cannot comply with the orders because of 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.
- In the event the patient is hospitalized, the admitting physician should evaluate the patient and review the POST form. New orders may be recommended based on the patient's condition and their known preferences or, if unknown, the patient's best interest.

Reviewing Physician Orders for Scope of Treatment (POST)

This form should be periodically reviewed in the following circumstances:

- There is a substantial change in the patient's health status.
- The patient is transferred from one care setting or care level to another or the treating physician changes.
- The patient's treatment preferences change.

Voiding Physician Orders for Scope of Treatment (POST)

- A person with capacity, or the valid representative of a person without capacity, can void the POST orders at any time by any of the following: a signed and dated writing; physical cancellation or destruction; by another individual at the direction of the declarant or representative; or an oral expression. The revocation is effective upon communication to a health care provider.