HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

PROVIDER ORDERS FOR SCOPE OF TREATMENT (POST)

FIRST follow these orders, **THEN** contact physician. This is a medical order form based on the person's medical condition and preferences. Any section not completed implies full treatment for that section. POST complements a Power of Attorney for Health Care (POAHC) and is not intended to replace that document. Recognize the dignity of all people and treat everyone with respect.

PATIENT LAST NAME:	**PATIENT FIRST NAME:**	**M.I.:**
DATE OF BIRTH: (mm/dd/yyyy) _____ / _____ / _____	**GENDER:** ☐ MALE ☐ FEMALE	
ADDRESS: (street/city/state/zip)		

A. CARDIOPULMONARY RESUSCITATION (CPR): *If Patient has no pulse and is not breathing.*

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

CHECK ONE
- ☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B.)
- ☐ Do Not Attempt Resuscitation/DNR

B. MEDICAL INTERVENTIONS: *If Patient has pulse and is breathing.*

CHECK ONE
- ☐ FULL TREATMENT – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ *TRIAL PERIOD OF FULL TREATMENT*
- ☐ SELECTIVE TREATMENT – primary goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Transfer to hospital when indicated, generally avoid intensive care.
- ☐ COMFORT-FOCUSED TREATMENT – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

ADDITIONAL ORDERS: _____

C. ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food and fluids by mouth if feasible.*

In principle medically assisted nutrition and hydration are provided unless these measures cannot reasonably be expected to prolong life or when they would be excessively burdensome for the patient or would cause significant physical discomfort.

CHECK ONE
- ☐ Determine the use of artificial nutrition when needed.
- ☐ Long-term artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ No artificial nutrition by tube.

ADDITIONAL ORDERS: _____

D. DISCUSSION PARTICIPANTS:

CHECK ONE
- ☐ Patient (Patient has capacity)
- ☐ Health Care Agent – Name/phone: _____
- ☐ Parent of minor
- ☐ Court-Appointed Guardian – Name/phone: _____
- ☐ Other: _____

E. SIGNATURE OF PATIENT/AGENT/GUARDIAN: (either patient/agent/guardian must sign or health care professional must initial)

SIGNATURE: (recommended)	NAME: (print)	RELATIONSHIP: (write "self" if patient)

☐ The signing health care professional has initialed this box to verify that the patient/agent/guardian consent to these orders but was unwilling or unable to sign in the space above.

F. SIGNATURE OF HEALTH CARE PROFESSIONAL:

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

HEALTH CARE PROFESSIONAL SIGNATURE: (required) (i.e., Licensed Physician, Physician Assistant, Nurse/Advance Nurse Practitioner)	PRINT SIGNING HEALTH CARE PROFESSIONAL NAME: (required)	TIME AND DATE: (required)

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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PATIENT NAME:

Decisions on the POST form are voluntary, informed decisions. This POST form records your wishes for medical treatment in your current state of health if there is a medical emergency outside of the hospital.

During the course of your medical treatment risks and benefits of your chosen therapy may change. Your decisions and this form can be changed by you (or your agent or guardian) to reflect your new wishes at any time (contact your health care professional to make any changes to this form). No form can address all the medical treatment decisions that may need to be made. A Power of Attorney for Health Care (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC is recommended for all capable adults and allows you to document in detail your general health care instructions and name a health care agent to speak for you if you are unable to speak for yourself. Consider reviewing your POAHC and giving a copy of it to your health care professional.

CONTACT INFORMATION

PREPARER NAME:	**PREPARER TITLE:**	**PHONE NUMBER:**
PRIMARY CARE PROFESSIONAL:		**DATE PREPARED:** (mm/dd/yyyy)

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING POST

- Decisions on a POST are voluntary, informed decisions.
- Should reflect current preferences of persons with serious advanced illness or frailty. Encourage completion of a Power of Attorney for Health Care.
- Verbal/phone orders are acceptable with follow-up signature by health care professional in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies on canary yellow paper or faxes are acceptable in a skilled nursing facility, assisted living/community based residential facility (CBRF) or in home hospice.
- Health care professionals should always include patients, including those with developmental disabilities or significant mental health conditions, in the conversation to the extent possible before completing the POST form.
- The POST is available to providers in all La Crosse area health care facilities. To obtain the document in La Crosse, or for use by providers in other Wisconsin health care facilities, please use the following link: http://www.gundersenhealth.org/advance-care/resources.

USING POST

- Any incomplete section of POST implies full treatment for that section.

SECTION A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen “Do Not Attempt Resuscitation.”

SECTION B:

- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort-Focused Treatment,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture.)
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not “Comfort-Focused Treatment.”
- EMS protocols are written based on this form; “additional orders” written in Section B may not be implemented by EMS if they go beyond the scope of their protocols.

REVIEWING POST

This POST should be reviewed periodically and if:

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

VOIDING POST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw a line through sections A through E 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.

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