

POST Form (Physician Orders for Scope of Treatment)

The POST form is a medical order form intended for people with serious health conditions. It is issued by your physician to inform other health care providers about your treatment wishes. Almost everyone wants their treatment wishes respected, especially at the end of life. The POST form is a way you can ensure that those treating you will know and respect your wishes. You should discuss the various treatments on the form with your doctor and then review it before signing it to be certain that it orders the treatment that you want. Your doctor must also sign it for the form to be valid. The form must accompany you to any medical facility where care may be given. Any section left incomplete will tell providers to administer full treatment.

If you would like a **POST** form, ask your physician for one at your next appointment.

Section A
This section provides orders regarding cardiopulmonary resuscitation (CPR). People who prefer a natural death request their doctors to check the Do Not Attempt Resuscitation box.

Section B
This section provides choices regarding how aggressive you want your medical treatment to be. **Full treatment** involves all measures to keep you alive including use of CPR and a breathing machine in an intensive care unit. **Limited additional interventions** include intravenous fluids and heart monitoring but not intensive care. Patients will not receive CPR with this order. **Comfort measures** include treatments to preserve patient dignity without the use of machines. Patients with a comfort measures order will usually be kept comfortable at home or in a nursing home. They will not be transferred to the hospital unless the patient cannot be kept comfortable where they live.

Section C
This section provides choices regarding antibiotics. Patients who want to allow a natural death may decide not to have antibiotics.

Section D
This section provides choices regarding medically administered fluids and nutrition through an intravenous line or tube. It gives the choices of no fluids or nutrition at all through a tube, fluids and nutrition only for a short time, or fluids and nutrition for the rest of your life.

Section E
This section indicates who made the decisions with the doctor and how they were made.

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED								
Physician Orders for Scope of Treatment (POST) <small>This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.</small>		Last Name/First/Middle Initial Address City/State/Zip Date of Birth (mm/dd/yyyy) Last 4 SSN Gender <input type="checkbox"/> M <input type="checkbox"/> F						
Section A <small>Check One Box Only</small>	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. <input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) <small>When not in cardiopulmonary arrest, follow orders in B, C, and D.</small>							
Section B <small>Check One Box Only</small>	MEDICAL INTERVENTIONS: Person has pulse and/or 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 only 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 <small>Check One Box Only</small>	ANTIBIOTICS <input type="checkbox"/> No Antibiotics <input type="checkbox"/> Antibiotics Other Instructions: _____							
Section D <small>Check One Box Only in Each Column</small>	Medically Administered Fluids and Nutrition: Oral fluids and nutrition must be offered if medically feasible. <table border="0"> <tr> <td><input type="checkbox"/> No IV fluids (provide other measures to assure comfort)</td> <td><input type="checkbox"/> No feeding tube</td> </tr> <tr> <td><input type="checkbox"/> IV fluids for a defined trial period</td> <td><input type="checkbox"/> Feeding tube for a defined trial period</td> </tr> <tr> <td><input type="checkbox"/> IV fluids long-term if indicated</td> <td><input type="checkbox"/> Feeding tube long-term</td> </tr> </table> Other Instructions: _____		<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
<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							
Section E	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> MPOA representative <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Spouse <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's preferences unknown) <input type="checkbox"/> (Other) _____						
Physician Name (Print)		Physician Phone Number						
Physician Signature (Mandatory)		Date						
FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED								

©Center for End-of-Life Care, Robert C. Byrd Health Sciences Center of West Virginia University, P.O. Box 9022, Morgantown, WV 26506, 1-877-209-8086 2010



1195 Health Sciences North
Morgantown, WV 26506-9022

877-209-8086

www.wvendoflife.org

POST Form (Physician Orders for Scope of Treatment)

The POST form is used to inform medical providers about your treatment wishes. Your doctor can issue a POST form to you. The doctor must complete and sign Section E for the form to be valid. The form must accompany you to any medical facility where care may be given. Any section left incomplete will tell providers to administer full treatment.

If you live at home, the POST form should be kept on your refrigerator with a magnet. Rescue squads have been instructed to look on the refrigerator for the form. If you live in a nursing home or personal care home, your POST form will be kept in the front of your medical chart. If you are a patient in the hospital, take the form with you and the nurse will put the form in your chart while you are in the hospital. Be sure to take it home with you when you leave.

FAX your **POST** form to the WV e-Directive Registry so that your wishes will be known and available when needed.

Section F

This section indicates what advance directives you have completed and who you want to make decisions for you if you cannot speak for yourself. This section also includes a box which you can initial to give that person authority to make all medical decisions for you in the future if you become unable to make them yourself. There is a space for you to sign the form.

Opt-In to WV e-Directive Registry

Initial this box if you wish to have your health care provider FAX a copy of your form to the WV e-Directive Registry.

Section G

This section provides space for review of the orders on the POST form when your condition changes or when you are admitted to the hospital. Each time the form is reviewed, your doctor will complete a line in this section.

For questions about this form or anything else concerning advance directives or DNR cards call:

877-209-8086

WV e-Directive Registry FAX

304-293-7442

www.wvendoflife.org

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Review of POST Last Name/First/Middle Initial

This form should be reviewed if there is substantial change in patient/resident health status, or patient/resident treatment preferences change. According to state law, the form must be reviewed if the patient/resident is transferred from one health care setting to another.

If this form is to be voided, write the word "VOID" in large letters on the front of the form. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Section F	Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form				
Advance Directive (Living Will or MPOA)*	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy			
Organ and Tissue Document of Gift	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation			
Court-appointed Guardian*	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation			
Health Care Surrogate Selection*	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation			
*Contact Name: _____		Phone: _____			
<input type="checkbox"/> If I lose decision-making capacity, I authorize my medical power of attorney representative/health care surrogate to make all medical decisions for me, including those regarding CPR and other life-sustaining treatment and to complete a new form (Initials in box indicate patient acceptance of this statement).					
Opt In <input type="checkbox"/> Initial box if you agree to have your POST form, do not resuscitate card, living will and medical power of attorney form (if completed) submitted to the WV eDirective Electronic Registry and released to treating health care providers.					
Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)				Date	
Signature of Person Preparing Form		Preparer Name (Print)		Date Prepared	
Section G	Review of this POST Form				
	Date of Review	Reviewer	Physician Signature	Location of Review	Outcome of Review
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
					<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

©Center for End-of-Life Care, Robert C. Byrd Health Sciences Center of West Virginia University, P.O. Box 9022, Morgantown, WV 26506, 1-877-209-8086 2010

DO NOT ALTER THIS FORM !

