

Idaho Physician Orders for Scope of Treatment (POST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- This form must be signed by an authorized practitioner in **Section E** to be valid
- If any section is **NOT COMPLETE** provide the most comprehensive treatment in that section
- EMS: If questions arise contact on-line **Medical Control**

Last name _____

First name _____

Date of birth ____/____/____

Last four digits of SS # _____

☐ Male ☐ Female

Section

A

Select

1

OR

2

Cardiopulmonary Resuscitation: Patient is not breathing and/or does not have a pulse☐ **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions☐ **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)**Additional resuscitation instructions:** _____

Section

B

Select

only

ONE box

Medical interventions: Patient has a pulse and is breathing☐ **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**☐ **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.☐ **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

Section

C

Artificial Fluids and Nutrition:☐ Yes ☐ No Feeding tube☐ Yes ☐ No IV fluids

Other instructions: _____

Antibiotics and blood products:☐ Yes ☐ No Antibiotics☐ Yes ☐ No Blood products

Other instructions: _____

Section

D

Advance Directives: The following documents also exist:☐ Living Will ☐ DPAHC ☐ Other _____

Section

E

☐ I request that this document be submitted to the Idaho Health Care Directive Registry**Patient/Surrogate Signature:** ☒

Print Patient/Surrogate name

Relationship (Self, Spouse, etc.)

____/____/____

Date

Physician/APPN/PA Signature: ☒

Print Physician/APPN/PA name

ID license number

Phone # ____ - ____ - ____

____/____/____

Date

Discussed with: ☐ Patient ☐ Spouse ☐ DPAHC ☐ Other _____The basis for these orders is: ☐ Patient's request ☐ Patient's known preference

ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED

PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED

COPY OF ORIGINAL LEGALLY VALID

Directions for Healthcare professionals

Completing the POST

- Use of the form is designed for persons with advanced chronic, progressive and/or end-stage illness
- For information on how to complete the POST online go to this site <http://www.sos.idaho.gov/>, click on the "Health Care Directive Registry" link, then click on "POST Login" link, then click on the "Instructions" link
- The POST form is also available for on-line completion on the Idaho Secretary of State Health Care Registry Website: <http://www.sos.idaho.gov/general/hcdr.htm>
- In order to be valid, the POST form must be completed by a physician (physician assistant when delegated) or Advanced Practice Professional Nurse (APPN) using patient preferences and medical indications
 - If the goal is to support quality of life using only comfort measures in the last phases of life, then select number 1 in section A
 - If the goal is to support both function and quality of life then any selection in section A may be appropriate
 - If the goal is for aggressive treatment and to live as long as possible then select number 2 in section A
- The patient/surrogate should be instructed to initial the first box in Section E if they would like to request their POST be submitted to the Idaho Healthcare Directive registry
- If applicable, provide the patient with information on how to obtain a DNR POST necklace or bracelet. To do so, go to the following web address to download the order form: www.idahoendoflife.org

Using the POST

- If any section is NOT COMPLETE provide the most comprehensive treatment in that section
- An automatic external defibrillator (AED) should not be used if the patient has selected "Do not resuscitate" or "No" to "defibrillation" in section A
- Oral fluids and nutrition must always be offered if medically feasible
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only" should be transferred to a setting conducive to achieving comfort
- Artificially administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.
- A patient with capacity or the surrogate (if patient lacks capacity) can temporarily suspend or revoke the POST at any time and request alternative treatment

Reviewing the POST

- The POST shall be reviewed:
 1. Each time the physician, PA or APPN examines the patient, or at least every seven days, for patients who are hospitalized, OR
 2. Each time the patient is transferred from one care setting or level of care to another, OR
 3. Each time there is substantial change in the patient health status, OR
 4. Each time the patient's treatment preferences change

Failure to meet these review requirements does not affect the POST form's validity or enforceability. As conditions warrant, the physician or nurse practitioner may issue a superseding POST form in consultation with the patient or the patient's agent.

Information for Patients

1. Anytime you access healthcare please make your healthcare provider aware that you have a POST
2. If you have a necklace, bracelet or a Health Care Directive card, please show them your Healthcare Directive ID number. Otherwise, you may want to carry a copy of your POST with you.
3. Please inform family members and/or friends if you wish them to be aware that you have a POST
4. Your POST is honored in any healthcare setting in the State of Idaho and in some other states (check with State laws)
5. You have the right at any time to revoke or initiate a new POST to reflect your current wishes
6. Display your POST form in a prominent location in your home. On the refrigerator is most recommended.