

## POST (PHYSICIAN ORDERS FOR SCOPE OF TREATMENT)

**Property of patient listed below – Send original with patient when transferred or discharged  
COPY FOR ARCHIVE PURPOSES ONLY**

### SUMMARY OF PHYSICIAN ORDERS for Scope of Treatment (POST)

This Summary of Physician Orders is based on patient/resident medical condition and wishes. It summarizes any Advance Directive. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient	Last Name	First Name/Middle Initial	Date of Birth
<b>Section A</b> Check one box only	<b>RESUSCITATION. Patient/resident has no pulse <u>and</u> is not breathing.</b> <input type="checkbox"/> Resuscitate <input type="checkbox"/> Do Not Resuscitate (DNR) <input type="checkbox"/> Limited Do Not Resuscitate (DNR) instructions: _____ When not in cardiopulmonary arrest, follow orders in Section B, C and D		
<b>Section B</b> Check one box only	<b>MEDICAL INTERVENTIONS. Patient/resident has pulse <u>and/or</u> is breathing.</b> <input type="checkbox"/> <b>Comfort Measures Only.</b> The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. The patient/resident is not to be hospitalized unless comfort measures fail. <input type="checkbox"/> <b>Limited Additional Interventions.</b> Include care above. May include cardiac monitor and oral/IV medications. Transfer to hospital if indicated, but no endotracheal intubation or long term life support measures. Usually no intensive care. <input type="checkbox"/> <b>Full Treatment.</b> Includes care above plus endotracheal intubation and cardioversion. <i>Other Instructions:</i>		
<b>Section C</b> Check one box only	<b>LIFE-SUSTAINING ANTIBIOTICS. Comfort measures are always provided.</b> <input type="checkbox"/> No Life-sustaining Antibiotics <input type="checkbox"/> Administer Antibiotics as necessary <i>Other Instructions:</i>		
<b>Section D</b> Check one box only	<b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION. Comfort measures always provided.</b> <input type="checkbox"/> No Feeding Tube/IV Fluids <input type="checkbox"/> Defined Trial Period of Feeding Tube/IV Fluids <input type="checkbox"/> Long Term Feeding Tube/IV Fluids <i>Other Instructions:</i>		
<b>Section E</b>	<b>The preferences above were discussed with:</b> <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Spouse <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Health care proxy <input type="checkbox"/> Other:		<b>Summarize Medical Condition</b>
	<b>Date</b>	<b>Physician Phone No.</b>	<b>Physician Name (print)</b>
<b>Physician Address:</b>			
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<b>Section F</b>	<b>Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POST Form</b>		
	<p><b>I have given significant thought to life-sustaining treatment. I expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following documents/persons have further information regarding my preferences:</b></p> <p>Advance Directive <input type="checkbox"/> NO <input type="checkbox"/> YES    Durable Power of Attorney for Health Care <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>My appointed proxy #1 is _____ Telephone Number _____</p> <p>My appointed proxy #2: is _____ Telephone Number _____</p> <p>If none appointed, contact: _____ Telephone Number _____</p> <p>Court-Appointed Guardian <input type="checkbox"/> NO <input type="checkbox"/> YES, _____ Contact _____</p> <p style="padding-left: 150px;">Telephone Number _____</p>		
	Signature of Patient / Resident; Parent of Minor; or Guardian / Proxy (optional)		
	Signature of Person Preparing Form	Preparer Name (print)	Date Prepared

<b>Section G</b>	<b>Two (2) witnesses are required if the POST is to serve as a Declaration (Advance Directive)</b>		
	Witness Signature (optional)	Witness Name (print)	Date Signed
	Witness Address:		Witness Telephone:
	Witness Signature (optional)	Witness Name (print)	Date Signed
	Witness Address:		Witness Telephone:

**WHEN THIS FORM SHOULD BE REVIEWED**

This form (POST) should be reviewed periodically and if:

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

If this form is to be voided, write "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 H	Date	Reviewer	Location of Review	Outcome of Review
Review of this POST Form				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <b>no</b> new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <b>no</b> new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <b>no</b> new form

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## **POST (PHYSICIAN ORDERS FOR SCOPE OF TREATMENT)**

The POST form can be obtained from NCEHP. As it is important that the forms remain uniform for easy recognition, NCEHP will be the sole distributor of the POST forms. It is also very important that any facility planning on implementing the POST form have training on its completion and implementation. Please contact NCEHP for more information.