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 healthcare provider to inform other 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 health-care provider 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.

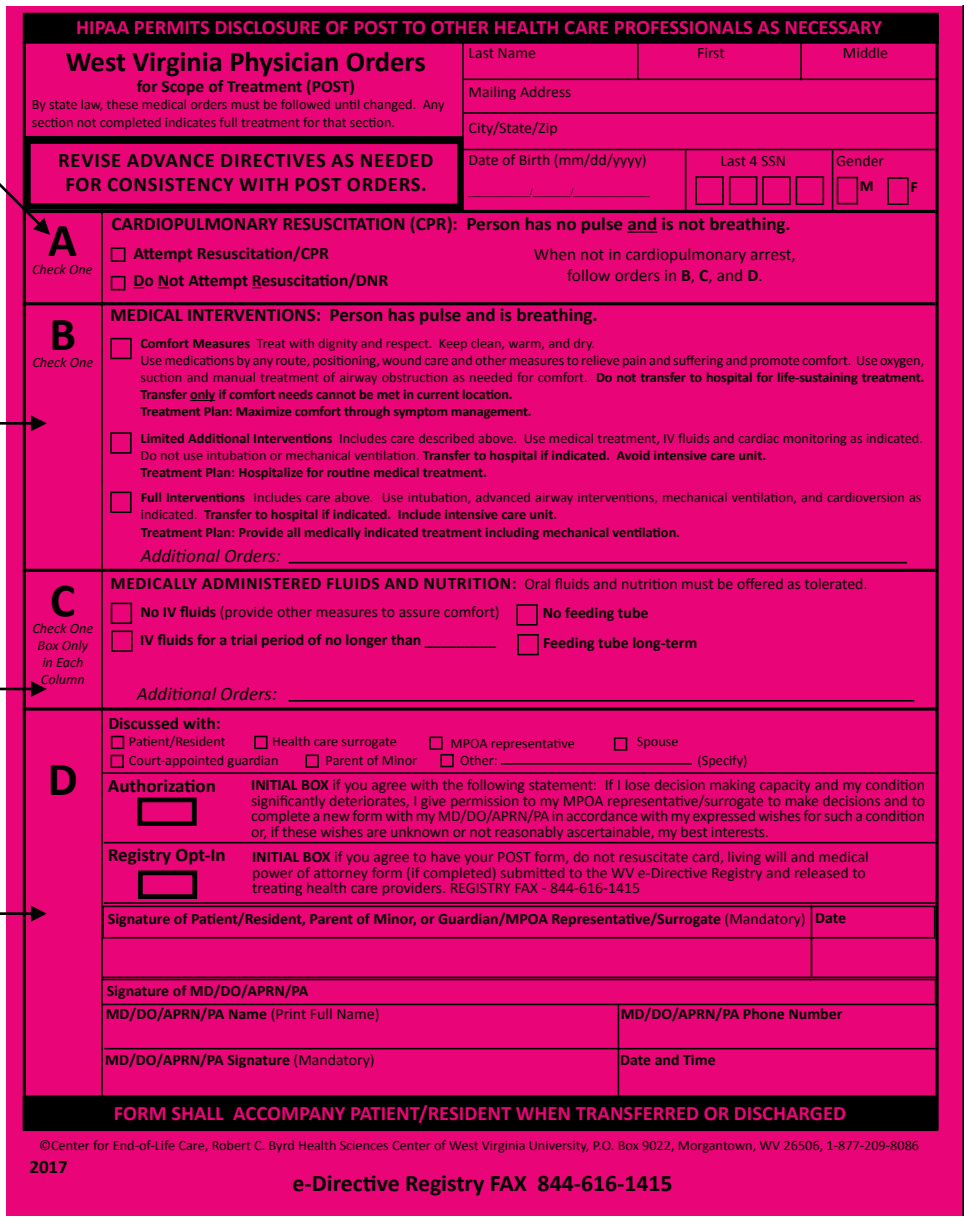
If you would like a **POST** form, ask your healthcare provider for one at your next appointment.

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 Intervention** 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 they cannot be kept comfortable where they live.

Section C
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 only for a period of time, or nutrition for the rest of your life.

Section D
This section includes a box which you can initial to give the person you have chosen to make medical decisions for you the authority to make all medical decisions for you in accordance with your wishes if you become unable to make them yourself. This section also includes a box to initial if you wish to have this form submitted to the e-Directive Registry. There is a space for you to sign the form.



HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

West Virginia Physician Orders for Scope of Treatment (POST)
By state law, these medical orders must be followed until changed. Any section not completed indicates full treatment for that section.

REVISE ADVANCE DIRECTIVES AS NEEDED FOR CONSISTENCY WITH POST ORDERS.

Last Name | First | Middle
Mailing Address
City/State/Zip
Date of Birth (mm/dd/yyyy) ___/___/___ | Last 4 SSN | Gender ☐M ☐F

A *Check One*
CARDIOPULMONARY RESUSCITATION (CPR): Person 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: Person has pulse and is breathing.
☐ **Comfort Measures** Treat with dignity and respect. Keep clean, warm, and dry. Use medications by any route, positioning, wound care and other measures to relieve pain and suffering and promote comfort. 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. Treatment Plan: Maximize comfort through symptom management.**
☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care unit. Treatment Plan: Hospitalize for routine medical treatment.**
☐ **Full Interventions** Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care unit. Treatment Plan: Provide all medically indicated treatment including mechanical ventilation.**
Additional Orders: _____

C *Check One Box Only in Each Column*
MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Oral fluids and nutrition must be offered as tolerated.
☐ **No IV fluids** (provide other measures to assure comfort) ☐ **No feeding tube**
☐ **IV fluids for a trial period of no longer than** _____ ☐ **Feeding tube long-term**
Additional Orders: _____

D
Discussed with:
☐ Patient/Resident ☐ Health care surrogate ☐ MPOA representative ☐ Spouse
☐ Court-appointed guardian ☐ Parent of Minor ☐ Other: _____ (Specify)

Authorization ☐ **INITIAL BOX** if you agree with the following statement: If I lose decision making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new form with my MD/DO/APRN/PA in accordance with my expressed wishes for such a condition or, if these wishes are unknown or not reasonably ascertainable, my best interests.

Registry Opt-In ☐ **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 e-Directive Registry and released to treating health care providers. REGISTRY FAX - 844-616-1415

Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory) | **Date**

Signature of MD/DO/APRN/PA
MD/DO/APRN/PA Name (Print Full Name) | **MD/DO/APRN/PA Phone Number**
MD/DO/APRN/PA Signature (Mandatory) | **Date and Time**

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

2017
e-Directive Registry FAX 844-616-1415

West Virginia Center for End-of-Life Care
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 healthcare provider can issue a POST form to you. They must complete and sign Section D 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 E
This section indicates what advance directives you have competed and who you want to make decisions for you if you cannot speak for yourself.

Section F
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.

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Last Name	First	Middle

E — **Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form**

Advance Directive (Living Will or MPOA)	☐ NO	☐ YES - Attach copy of documentation
Organ and Tissue Document of Gift	☐ NO	☐ YES - Attach copy of documentation
Court-appointed Guardian	☐ NO	☐ YES - Attach copy of documentation
Health Care Surrogate Selection	☐ NO	☐ YES - Attach copy of documentation

MPOA/Surrogate/Court-appointed Guardian/Parent of Minor Contact Information

Name	Address	Phone

Person Preparing Form

Signature of Person Preparing Form	Preparer Name (Print)	Date Prepared

F — **Review of this POST Form**

Date of Review	Reviewer	MD/DO/APRN/PA Signature	Location of Review	Outcome of Review
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form

Review of POST Form
This form should be reviewed if there is substantial change in patient/resident health status or patient/resident treatment preferences. 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, note that full treatment and resuscitation may be provided.* FAX voided form and newly completed form to the Registry. Additional forms can be obtained by calling 877-209-8086 or ordered online from the WV Center for End-of-Life Care website at www.wvendoflife.org/Request-Information.

Instructions for Submission to the WV e-Directive Registry (if Opt-In Box is initialed)
FAX a copy of BOTH sides of the POST form to the e-Directive Registry at 844-616-1415. Copy form on your copy machine and adjust the lightness/darkness to contrast depending on your machine so that the form is readable prior to FAXing to the Registry. If you have questions about submission of this POST form or other advance directive documents to the Registry, call 877-209-8086. If you are using POST forms that were printed prior to 2010 and wish to submit them to the Registry, please complete a Sign-Up Form that contains the additional demographic information needed to identify the patient/resident in the Registry. The Sign-Up Form can be downloaded at www.wvendoflife.org/e-Directive-Registry.

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

e-Directive Registry FAX 844-616-1415

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

877-209-8086

WV e-Directive Registry

FAX 844-616-1415

www.wvendoflife.org

West Virginia Center for End-of-Life Care

WEST VIRGINIA Department of Health & Human Resources