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

West Virginia
POST
Physician Orders for Scope of Treatment
A Participating Program of National POLST

By state law, these medical orders must be followed until changed. Any section not completed indicates full treatment for that section.

Having a POST form is always voluntary

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 ☐☐☐☐	Sex ☐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)

☐ **IV fluids for a trial period of no longer than** _____

☐ **No feeding tube**

☐ **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

2020

e-Directive Registry FAX 844-616-1415

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	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
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				☐ 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 <u>must</u> 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