Physician Orders
for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, ***first*** follow these orders, ***then*** contact physician.

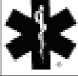
Name Last / First / M. I.

Address

City / State / Zip

Date of Birth (mm/dd/yyyy)

Last 4 Digits SSN ☐ ☐ ☐ ☐



ATTENTION — ONLY Section A applies to EMS.
When not in cardiopulmonary arrest, EMS will follow Operational Protocol.

A ✓ one only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **Resuscitate** ☐ **Do Not Attempt Resuscitation (DNR/No CPR)**

When not in cardiopulmonary arrest, follow orders in B, C and D.

B ✓ one only

MEDICAL INTERVENTIONS: Patient has pulse and / or is breathing.

☐ **Comfort Measures:** Treat with dignity and respect. Keep 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.**

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). **Transfer to hospital if indicated. Avoid intensive care unit.**

☐ **Full Interventions:** Includes care above. Use intubation, mechanical ventilation and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care unit.**

Other Instructions: ____________________

C ✓ all that apply

ANTIBIOTICS

☐ **NO** Antibiotics

☐ **ORAL** Antibiotics ☐ **IM** Antibiotics ☐ **IV** Antibiotics

Other Instructions: ____________________

SAMPLE

D ✓ one box only in each column

ARTIFICIALLY ADMINISTERED HYDRATION AND NUTRITION: Always offer food and fluids by mouth if feasible.

☐ **NO** IV Hydration

☐ IV Hydration for a **defined trial period***

☐ IV Hydration **long-term if indicated**

☐ **NO** feeding tube

☐ Feeding tube for a **defined trial period***

☐ Feeding tube **long-term if indicated**

*Specify length of trial period in Other Instructions in Section D.

Other Instructions: ____________________

E

DISCUSSED WITH:

☐ Patient
☐ Agent under Advance Medical Directive
☐ Court-appointed guardian
☐ Person authorized to consent on patient's behalf.
Relationship to patient **(required)**: ____________________

FACILITY OF ORIGIN

☐ CCRMH
☐ FHRC
☐ Richfield
☐ Hospice ____________________
☐ Other ____________________

Physician Name (Print)

Physician Phone

Physician Signature (Mandatory)

Date

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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Information for Patient Named on This Form

This form records the patient's direction for life-sustaining treatment in the patient's current state of health. It can be reviewed and updated by the patient's healthcare professional at any time the patient's preferences change. If the patient is unable to make his/her own healthcare decisions, the orders should reflect the patient's preferences as best understood by the person authorized to consent on the patient's behalf under Virginia law.

Signature of the Patient or the Person Authorized to Consent on Patient's Behalf

Signature	Name (Print)	Relationship (Write "Self" if patient)

Signature of Two Witnesses Required

The declarant signed the foregoing POST form in our presence:

Witness (Signature): ______________________

(Printed Name): ______________________

Witness (Signature): ______________________

(Printed Name): ______________________

SAMPLE

Contact Information

Person Authorized to Sign on Patient's Behalf (Optional)	Relationship	Phone	Address

Signature of Healthcare Professional Preparing Form	Title	Phone	Date Prepared

Directions for Healthcare Professionals

Completing POST

- Should reflect patient's current preferences. Encourage completion of a separate advance medical directive as well.
- POST must be signed by a physician who has a bona fide physician/patient relationship with the patient to be valid. Verbal orders are **NOT** acceptable.
- Use of original form is **REQUIRED**. Therefore, the original form **must** accompany the patient when transferred or discharged.

Using POST

Section B

- When comfort cannot be achieved in the current setting, the patient, including someone who has chosen "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."

Section D

- Oral fluids and nutrition **must** always be offered if medically feasible.

General

- If the POST form was signed by the patient, then only the patient can revoke or modify the form and request alternative treatment. If the POST form was signed by a person authorized to sign on the patient's behalf because the patient lacked capacity to make medical decisions, then the authorized person can revoke or modify the form and request alternative treatment as long as the patient lacks decision-making capacity. Voiding or modifications of the form may be made verbally or in writing, and by marking through or otherwise obliterating the form.

Reviewing POST

This POST should be reviewed periodically, and when:

- The patient is transferred from one care setting or care level to another;
- There is a substantial change in the patient's health status, OR
- The patient's treatment preferences change.

Draw a line through Sections A through E and write **"VOID"** in large letters if POST is voided or replaced.

FORM SHALL ACCOMPANY PATIENT / RESIDENT WHEN TRANSFERRED OR DISCHARGED