HIPAA permits disclosure to health care professionals as necessary for treatment.

**Indiana Physician Orders for Scope of Treatment (POST)**

Follow these orders first. Contact treating physician, advanced practice nurse, or physician assistant for further orders if indicated. Emergency Medical Services (EMS) should contact Medical Control per protocol. These medical orders are based on the patient’s current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

### A. Cardiopulmonary Resuscitation (CPR): Patient has no pulse AND is not breathing

- [ ] Attempt Resuscitation/CPR
- [ ] Do Not Attempt Resuscitation/DNR

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

### B. Medical Interventions: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

- [ ] Comfort Measures (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital** for life-sustaining treatments. **Transfer to hospital ONLY if comfort needs cannot be met in current location.**

  **Treatment Goal:** Maximize comfort through symptom management.

- [ ] Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. **Do not intubate.** **Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.**

  **Treatment Goal:** Stabilization of medical condition.

- [ ] Full Intervention In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer to hospital and/or intensive care unit if indicated to meet medical needs.**

  **Treatment Goal:** Full interventions including life support measures in the intensive care unit.

**Additional Orders:**

### C. Antibiotics:

- [ ] Use antibiotics for infection only if comfort cannot be achieved fully through other means.

**Additional Orders:**

### D. Artificially Administered Nutrition: Always offer food and fluid by mouth if feasible

- [ ] No artificial nutrition.
- [ ] Defined trial period of artificial nutrition by tube. (Length of trial: ______ Goal: _____________)

**Additional Orders:**

### E. Documentation of Discussion:

Orders discussed with (check one):

- [ ] Patient (patient has capacity)
- [ ] Legal Guardian/Parent of Minor
- [ ] Health Care Representative
- [ ] Health Care Power of Attorney

**Signature of Patient or Legally Appointed Surrogate (see back)**

**Signature (required)**  
**Print Name (required)**  
**Date (required)**

### F. Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s current medical condition and preferences.

**Print Signing Physician Name (required)**  
**Physician office Phone Number**  
**License Number**  
**Physician Signature (required)**  
**Date (required)**  
**Office Use Only**
The POST form is always voluntary. POST is based on your goals of care and records your wishes for medical treatment. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An Advance Directive, including appointing someone to speak on your behalf if you cannot speak for yourself, is recommended. You can identify a health care representative in the box below if you have not already done so.

Designation of Health Care Representative (Optional)

I hereby appoint: Name: _________________________________ phone #: (            ) ______________________
Relationship to patient: _______________ Address: ______________________________________________________
as my representative to act in my behalf on all matters concerning my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care.

Patient Signature: __________________________ Date: ________________ Witness (adult other than legally appointed surrogate): __________________________

Contact Information

Surrogate identified in section E (required if patient has no capacity) Address: __________________________ Phone Number: __________________________
Healthcare Professional Preparing Form Preparer Title: __________________________ Phone Number: __________________________

Directions for Health Care Professionals

Completing POST
- POST orders should reflect current treatment preferences of the patient.
- If the patient lacks decisional capacity, form may be completed by legally appointed guardian, healthcare representative, healthcare power of attorney, or parent of minor. The authority of the named surrogate is bound by Indiana statutes.
- Verbal / phone orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- The POST form is the personal property of the patient. Use of original form is encouraged, however photocopies and faxes are also legal and valid.

Using POST
- Any section of these Medical Orders not completed implies full treatment for that section.
- Oral fluids and oral nutrition must always be offered if medically feasible.
- Comfort care is never optional. When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., hip fracture).
- Persons who are in need of emergency medical services due to a sudden accident or injury outside the scope of the person’s illness should receive treatment to manage their medical needs.
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment” in section B on page one of this form.
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns and revise orders with the consent of the patient or authorized surrogate.
- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility and provide appropriate care in the meantime.
- In the event the patient is hospitalized, the admitting physician should evaluate the patient and review the POST form. New orders may be recommended based on the patient’s condition and their known preferences or, if unknown, the patient’s best interest.

Reviewing POST
This form should be periodically reviewed and in the following circumstances:
- There is a substantial change in the patient’s health status.
- The patient is transferred from one care setting or care level to another or the treating physician changes.
- The patient’s treatment preferences change.

Voiding POST
- A person with capacity, or the valid surrogate of a person without capacity, can void the POST orders and any time.
- Draw line through sections A through D and write “VOID” in large letters if POST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.