HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

South Carolina Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet. It is based on the patient's medical condition and wishes. **When the need occurs, first follow these orders, then contact physician**. In this document, the patient's legally authorized representative (LAR) means an agent under a Healthcare Power of Attorney, a surrogate under the Adult Healthcare Consent Act, or a court-appointed legal guardian.

Last Name of Patient/Resident:		Date:
First Name / MI:		
DOB: ___/___/___	Gender: M F	SSN (Last 4 Digits):

Patient's Diagnosis of Life-Limiting Condition:

A ***Check One Box Only***

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

When not in cardiopulmonary arrest, follow orders in Section B & C.

☐ **Attempt Resuscitation/CPR: Selecting CPR requires Full Treatment in Section B**

☐ **Do Not Attempt Resuscitation/DNR (Allow Natural Death) – no cardiopulmonary stimulation by electrical, mechanical or manual means may be made.**

B ***Check One Box Only***

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing

☐ **Full Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion, medical treatment, IV fluids as indicated; provide comfort measures. **Transfer to hospital, if indicated; includes intensive care. Re-evaluate Goals of Care if:** _____

☐ **Limited Interventions:** May use non-invasive positive airway pressure; **DO NOT intubate airway.** Use other medical treatment including IV fluids as indicated; provide comfort measures. **Transfer to hospital, if indicated; avoid intensive care if possible.**

☐ **Comfort Measures:** Keep clean, 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. **Transfer to hospital ONLY IF comfort needs cannot be met in current location.**

Additional Orders:

_____

C Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food / fluids by mouth as tolerated

☐ Long-term artificial nutrition by tube, if needed
☐ Trial period of artificial nutrition by tube:
Re-evaluate Goal of care if: _____
☐ Do not insert feeding tube
☐ Decide when/if the situation arises

Additional Orders: _____

D Check the Appropriate Boxes

PHYSICIAN DISCUSSION WITH (in order of legal priority):

☐ Patient
☐ Court-appointed legal guardian
☐ Healthcare agent or surrogate
☐ Spouse (not legally separated)
☐ Patient's adult child
☐ Patient's parent
☐ Patient's adult sibling or grandparent
☐ Other (explain): _____

Physician Signature: (Mandatory)	Date: (Mandatory)	Physician Name (type or print):	Phone Number:

Signature of Person or Legally Recognized Representative (Mandatory):

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician and this document reflects those treatment preferences.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative.

You are not required to sign this form to receive treatment.

Patient or Representative Signature:	Date :	Phone Number:

Patient or Representative Name (Print):	Relationship:

If Facilitator assists in preparing form:

NAME:	Title of Preparer:	Phone Number:	Date:

FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SC COALITION FOR THE CARE of the Seriously Ill

Pilot Project Form #_____

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Patient's Last Name:	First Name:	Middle Initial:	DOB:

Indications for Use

POST is physician orders based upon a patient's wishes concerning treatment at the end of life. The form is for persons eighteen years or older diagnosed with a life-limiting condition or advanced frailty.

Directions for Completing POST Form

- Must be prepared based on patient preferences and medical indications.
- Must be signed by a licensed physician (MD/DO).

Instructions for Use

- **In an emergency situation, POST should be followed by healthcare providers** as a valid physician order until the attending physician reviews the POST form and gives new orders. The physician should review form with patient or, if patient is unable, the LAR at the earliest available opportunity. D**ocument review of the POST and conversations about the POST in the medical record.**
- The basis for the POST order should be documented in the progress notes of the medical record**.**
- POST requires the signature of the patient or their legally authorized representative (LAR). If the patient's LAR is physically unavailable, place a copy of the completed form in the medical record with documentation of the LAR's oral consent. Send oral consent documentation during transport.
- Use of original form is encouraged. Photocopies or faxes of signed POST form are valid.
- There is no requirement to have a POST in order to receive treatment.
- **Section B**: Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag-valve mask (BVM) assisted respirations.
- A parenteral (IV/subcutaneous) medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Any section of POST not completed implies full treatment for that section.
- POST is part of Advance Care Planning (ACP), which may also include a Living Will and/or Healthcare Power of Attorney (HCPOA). If there is a Living Will, HCPOA or other advance directive, a copy should be attached if available.

Modifying and Voiding POST:

- **POST MAY BE REVOKED BY ORAL OR WRITTEN STATEMENT BY THE PATIENT OR LAR TO HEALTHCARE PERSONNEL.**
- If the patient or LAR wishes to revoke the POST or change treatment preferences, void the POST form by drawing a diagonal line across the front of the form, write VOID and sign/date on the line. A new POST may now be completed, if desired.

Reviewing POST:

POST should be reviewed periodically, such as when:

- the patient is admitted, transferred and/or discharged from one healthcare setting or care level to another
- the patient's health status substantially changes
- the patient's goal of treatment preferences change

Review Date/Time	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed

POST Repository Pilot

SC Coalition for Care of Seriously Ill (SCC CSI) is piloting this form in the South Carolina. SCC CSI has established a secure POST form repository at Roper St. Francis (RSF) in Charleston. Participation in the POST repository is voluntary. The patient or LAR may **fax both sides** of this form to the POST repository. The physician may do so unless the patient or LAR chooses not to participate by initialing **Opt Out of Repository**: ____. SCC CSI anticipates transferring POST forms in the RSF-based POST repository to an electronic repository available statewide upon legislative approval. Patients may also ask hospitals to add the patient's own POST to the hospital's electronic medical record as part of that patient's advance treatment plans.

Scan/Email form to wilma.rice@rsfh.com or fax to Roper St. Francis at 843-724-1961 – Attention POST Repository