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Idaho Physician Orders for Scope of Treatment (POST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- This form must be signed by an authorized practitioner in **Section E** to be valid
- **If any section is NOT COMPLETE provide the most comprehensive treatment in that section**
- **EMS:** If questions arise contact on-line **Medical Control**

Last name_____

First name_____

Date of birth___/___/_____

Last four digits of SS # ____

☐ Male ☐ Female

Section A — Select 1 OR 2

Cardiopulmonary Resuscitation: Patient is not breathing and/or does not have a pulse

☐ **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions

☐ **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

Additional resuscitation instructions: _____

Section B — Select only ONE box

Medical interventions: Patient has a pulse and is breathing

☐ **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**

☐ **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.

☐ **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

Section C

Artificial Fluids and Nutrition:

☐ Yes ☐ No Feeding tube

☐ Yes ☐ No IV fluids

Other instructions:_____

Antibiotics and blood products:

☐ Yes ☐ No Antibiotics

☐ Yes ☐ No Blood products

Other instructions: _____

Section D

Advance Directives: The following documents also exist:

☐ Living Will ☐ DPAHC ☐ Other _____

Section E

☐ **I request that this document be submitted to the Idaho Health Care Directive Registry**

Patient/Surrogate Signature: X _____

Print Patient/Surrogate name _____ Relationship (Self, Spouse, etc.) _____ Date __/__/__

Physician/APRN/PA Signature: X _____ Phone #___-___-____

Print Physician/APRN/PA name _____ ID license number _____ Date __/__/__

Discussed with: ☐ Patient ☐ Spouse ☐ DPAHC ☐ Other _____

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference

*****ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED*****

*****PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED*****

*****COPY OF ORIGINAL LEGALLY VALID*****

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