

# 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 Select 2	<p><b>Cardiopulmonary Resuscitation:</b> Patient is not breathing and/or does not have a pulse</p> <p><b>1. Do Not Resuscitate:</b> Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions</p> <p><b>2. Resuscitate (Full Code):</b> Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)</p> <p><b>Additional resuscitation instructions:</b> _____</p>
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Section B Select only ONE box	<p><b>Medical interventions:</b> Patient has a pulse and is breathing</p> <p><b>Comfort measures only:</b> 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. <b>Transfer to higher level of care only if comfort needs cannot be met in current location.</b></p> <p><b>Limited additional interventions:</b> 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.</p> <p><b>Aggressive interventions:</b> In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)</p>
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Section C	<p><b>Artificial Fluids and Nutrition:</b></p> <p>Yes    No    Feeding tube</p> <p>Yes    No    IV fluids</p> <p>Other instructions: _____</p>	<p><b>Antibiotics and blood products:</b></p> <p>Yes    No    Antibiotics</p> <p>Yes    No    Blood products</p> <p>Other instructions: _____</p>
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Section D	<p><b>Advance Directives:</b> The following documents also exist:</p> <p>Living Will    DPAHC    Other _____</p>
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Section E	<p><input type="checkbox"/> I request that this document be submitted to the Idaho Health Care Directive Registry</p> <p><b>Patient/Surrogate Signature: X</b></p> <p>_____                  Print Patient/Surrogate name                  Relationship (Self, Spouse, etc.)                  Date</p> <p><b>Physician/APRN/PA Signature: X</b></p> <p>_____                  Print Physician/APRN/PA name                  ID license number                  Phone # _____ - _____ - _____                  _____                  Date</p> <p><b>Discussed with:</b>    Patient    Spouse    DPAHC    Other _____</p> <p>The basis for these orders is:    Patient's request    Patient's known preference</p> <p style="text-align: center;"><b>***ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED***</b></p> <p style="text-align: center;"><b>***PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED***</b></p> <p style="text-align: center;"><b>***COPY OF ORIGINAL LEGALLY VALID***</b></p>
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