

# IDAHO EMS BUREAU

## Physician Orders for Scope of Treatment (POST) form Instructions

### General Information:

- The POST form is available for on-line completion on the Idaho Secretary of State Health" Care Registry Website: <https://sos.idaho.gov/hcdr/>
- The form is password protected. Passwords are available to Idaho licensed physicians and" Idaho licensed health care facilities. To obtain a password, send an email with the physician" or facility name and license number to [idahopost@dhw.idaho.gov](mailto:idahopost@dhw.idaho.gov)
- The form is interactive and will not permit multiple entries where only one entry is allowed." The form should be completed on-line and then printed. Printing blank copies and hand" entering information is discouraged.
- Your computer must be attached to a printer in order to print a completed POST form.
- Once you close the POST form, Information entered on the form will NOT be saved.
- "Ctrl Z" on your keyboard will undo the last action (helpful for clearing a check from a box" in the form)

### Patient Information:

Enter the patient's Last Name, First Name, Date of Birth and check the patient's gender in the appropriate blocks.

Patient's Last Name:
Lastname
Patient's First Name:
Firstname
Date of Birth: 1/11/1911
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female

### Section A: Cardiopulmonary Resuscitation (CPR)

Indicate the patient's desire to either be resuscitated or not if the patient should be in cardiopulmonary arrest (no pulse and/or not breathing). Select ONLY ONE.

<p><b>Cardiopulmonary Resuscitation:</b> Patient does not have a pulse and/or is not breathing:</p> <p><input type="checkbox"/> <b>Resuscitate (Full Code)</b></p> <p><input checked="" type="checkbox"/> <b>Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures.</b></p> <p>If patient is not in cardiopulmonary arrest, please follow the orders found in <b>B</b>, and <b>C</b>.</p>
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## Section B: Medical Interventions

**Level of interventions:** Indicate the patient’s wishes for the level of additional interventions that he/she will receive. The choices on the form range from very limited, comfort measures to aggressive interventions. Select ONLY ONE of these three options.

**Other Instructions:** In addition to the one selection for general “Level of Intervention”, the patient may also add any additional specific intervention instructions not addressed on the form. If the patient chooses to defer additional intervention decisions to a surrogate, enter those instructions here.

<b>Medical Interventions:</b> Patient has a pulse and/or is breathing:	
<input checked="" type="checkbox"/>	<b>Comfort Measures:</b> Please treat patient with dignity and respect. Reasonable measures are to be made to offer food and fluids by mouth and attention must be paid to hygiene. Medication, positioning, wound care, and other measures shall be used to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>These measures are to be used where patient lives, do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.</b>
<input type="checkbox"/>	<b>Limited Additional Interventions:</b> In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to hospital if indicated but do not use intubation or advanced airway interventions. <b>Do not admit to Intensive Care.</b>
<input type="checkbox"/>	<b>Aggressive Interventions:</b> In addition to the care described above, you may include endotracheal intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. <b>Receiving hospital may admit to Intensive Care if indicated.</b>
<input type="checkbox"/>	<b>Other Instructions:</b> <input type="text"/>
<input type="text"/>	

## Section C: Artificial Fluids and Nutrition/Antibiotics and Blood Products

**Feeding Tube:** Check one box to indicate if the patient desires or declines to receive nutrition via a feeding tube.

**IV Fluid:** Check one box to indicate if the patient desires or declines IV fluids.

**Other Instructions:** In addition to the general selections for IV fluids and feeding tubes, the patient may also add any additional specific instructions concerning IV fluids and feeding tubes not addressed on the form. If the patient chooses to defer IV fluids and feeding tube decisions to a surrogate, enter those instructions here.

**Antibiotics:** Check one box to indicate if the patient desires or declines antibiotics.

**Blood Products:** Check one box to indicate if the patient desires or declines blood products.

**Other Instructions:** In addition to the general selections for Antibiotics and Blood Products, the patient may also add any additional specific instructions concerning antibiotics and blood products not addressed on the form. If the patient chooses to defer antibiotic and blood product decisions to a surrogate, enter those instructions here.

<p><b>Artificial Fluids and Nutrition:</b></p> <p><input checked="" type="checkbox"/> Feeding tube                      <input type="checkbox"/> No Feeding tube</p> <p><input type="checkbox"/> IV fluid                                      <input checked="" type="checkbox"/> No IV fluid</p> <p><input type="checkbox"/> Other Instructions: <input type="text"/></p> <p><input type="text"/></p>	<p><b>Antibiotics and Blood Products:</b></p> <p><input type="checkbox"/> Antibiotics                      <input type="checkbox"/> No Antibiotics</p> <p><input type="checkbox"/> Blood Products                      <input type="checkbox"/> No Blood Products</p> <p><input type="checkbox"/> Other Instructions: <input type="text"/> Defer these decisions to</p> <p><input type="text"/> DPAHC (Firstname, Lastname)</p>
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**Section D: Advance Directives:**

This section allows the patient to make known the existence of other advance directives such as a living will, durable power of attorney (DPA) and/or durable power of attorney for health care (DPAHC). If a directive exists that is not listed on the form, you may indicate the same in the open text field. If no such documents exist, leave this section blank.

<b>Advance Directives:</b> The following documents also exist:			
<input checked="" type="checkbox"/> Living Will	<input type="checkbox"/> DPA	<input checked="" type="checkbox"/> DPAHC	<input type="checkbox"/> _____

**Section E: Signatures:**

**Signatures:** In order to be valid, the POST form must be signed by the attending physician and either the patient or the patient’s surrogate. (click on the “PRINT” button in the upper right corner of the form after all data is entered and the form will print on the printer attached to your computer)

**Names:** Enter the patient’s and the physician’s first and last names in the appropriate blocks.

**Relationship:** In the “Relationship” block, enter the relationship of person signing the “Patient/Surrogate” block to the patient.

**Date:** The Date blocks on the form have a pull down arrow on the right side of the block. Click on the arrow and select the date that the form is signed.

**Discussed with:** Indicate with whom the decisions on the POST form were discussed.

**Basis:** Indicate if the basis for the POST is the patient’s request, the patient’s known preference or other (if the “other” box is checked, indicate the basis in the accompanying text field)

<b>Patient/Surrogate Signature:</b> _____		
Firstname Lastname	Patient	Jul 2, 2007
Print Patient/Surrogate Name	Relationship	Date
<b>Physician Signature:</b> _____		
Firstname Lastname, MD	11111111	Jul 2, 2007
Print Physician's Name	Idaho License Number	Date
<b>Discussed with:</b>	<input checked="" type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> DPA <input type="checkbox"/> DPAHC <input type="checkbox"/> Other _____	
<b>The basis for these orders is:</b> <input checked="" type="checkbox"/> Patient's request <input type="checkbox"/> Patient's known preference <input type="checkbox"/> _____		

**After the form is printed and signed:**

- Provide the original, signed POST form to the patient.
- Make copies as appropriate for the patient’s records and healthcare environment(s).
- Patients may register a copy of their completed post form with the Secretary of State's office. For inclusion in the health care directory, the post form must be accompanied by a registration request that may be downloaded from the Idaho Secretary of State Health Care Directive Registry website. Details about the registry and the registration request are available at: <https://sos.idaho.gov/hcdr/>