



## INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R6 / 6-23)

Indiana Department of Health – IC 16-36-6

**INSTRUCTIONS:** This form is a physician's order for scope of treatment. It should be filled out based on a discussion about the patient's current medical condition and preferences. It is voluntary and a patient may not be required to complete a POST form. The POST should be reviewed whenever the patient's condition changes. A patient may ask the health care provider to void the POST form at any time. If the patient lacks decisional capacity, the legal representative or proxy (if there is no legal representative) may complete POST on behalf of the patient and/or ask the health care provider to void POST. Any section left blank implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

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| Patient Last Name (required) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Patient First Name (required) |                            | Middle Initial |
| Birth Date (mm/dd/yyyy)      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Medical Record Number         | Date Prepared (mm/dd/yyyy) |                |
|                              | <b>DESIGNATION OF PATIENT'S PREFERENCES:</b> The following sections (A through D) are the patient's current preferences for scope of treatment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                            |                |
| <b>A</b><br>Check One        | <b>CARDIOPULMONARY RESUSCITATION (CPR):</b> Patient has no pulse AND is not breathing. (required)<br><input type="checkbox"/> Attempt Resuscitation / CPR <input type="checkbox"/> Do Not Attempt Resuscitation / DNR<br>When not in cardiopulmonary arrest, follow orders in <b>B</b> , <b>C</b> and <b>D</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               |                            |                |
| <b>B</b><br>Check One        | <b>MEDICAL INTERVENTIONS:</b> If patient has pulse AND is breathing OR has pulse and is NOT breathing.<br><input type="checkbox"/> <b>Comfort Measures (Allow Natural Death):</b> Treatment Goal: Maximize comfort through symptom management. 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.<br><input type="checkbox"/> <b>Limited Additional Interventions:</b> Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, 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.<br><input type="checkbox"/> <b>Full Intervention:</b> Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs. |                               |                            |                |
| <b>C</b><br>Check One        | <b>ANTIBIOTICS:</b><br><input type="checkbox"/> Use antibiotics for infection only if comfort cannot be achieved fully through other means.<br><input type="checkbox"/> Use antibiotics consistent with treatment goals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                            |                |
| <b>D</b><br>Check One        | <b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> Always offer food and fluid by mouth if feasible.<br><input type="checkbox"/> No artificial nutrition.<br><input type="checkbox"/> Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)<br><input type="checkbox"/> Long-term artificial nutrition.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                            |                |
|                              | <b>OPTIONAL ADDITIONAL ORDERS:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                            |                |
|                              | <b>SIGNATURE PAGE:</b> This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                            |                |

Patient Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

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|----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------|
|          | <b>SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY:</b> In order for the POST form to be effective, the patient, legal representative, or proxy must sign and date the form below.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                 |
| <b>E</b> | <b>SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY</b><br>My signature below indicates that the physician, advanced practice registered nurse, or physician assistant (or their designee) discussed with me the above orders and the selected orders correctly represent the decisions made during this discussion.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |                                                                                 |
|          | Signature <i>(required)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Print Name <i>(required)</i>                                | Date (mm/dd/yyyy) <i>(required)</i>                                             |
| <b>F</b> | <b>CONTACT INFORMATION FOR LEGAL REPRESENTATIVE OR PROXY IN SECTION E (IF APPLICABLE):</b> If the signature above is other than patient's, add contact information for the representative or proxy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                             |                                                                                 |
|          | Relationship of representative or proxy identified in Section E if patient does not have capacity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Address (number and street, city, state, and ZIP code)      | Telephone Number                                                                |
|          | <b>PHYSICIAN ORDER:</b><br>A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:<br>(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:<br>(A) the individual is a qualified person; and<br>(B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and<br>(2) the qualified person, representative, or proxy has signed and dated the POST form<br>A qualified person is an individual who has at least one (1) of the following:<br>(1) An advanced chronic progressive illness.<br>(2) An advanced chronic progressive frailty.<br>(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:<br>(A) there can be no recovery; and<br>(B) death will occur from the condition within a short period without the provision of life prolonging procedures.<br>(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death. |                                                             |                                                                                 |
| <b>G</b> | <b>DOCUMENTATION OF DISCUSSION: Orders discussed with (check one):</b><br><input type="checkbox"/> Patient (patient has capacity) <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Legal Guardian<br><input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Power of Attorney <input type="checkbox"/> Proxy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                             |                                                                                 |
| <b>H</b> | <b>SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT</b><br>My signature below indicates that I or my designee have discussed with the patient, patient's representative, or proxy the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |                                                                                 |
|          | Signature of Treating Physician / APRN / PA <i>(required)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Print Treating Physician / APRN / PA Name <i>(required)</i> | Date (mm/dd/yyyy) <i>(required)</i>                                             |
|          | Physician / APRN / PA office telephone number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Physician / APRN / PA License Number                        | Health Care Professional preparing form if other than the physician / APRN / PA |
| <b>I</b> | <b>APPOINTMENT OF HEALTH CARE REPRESENTATIVE:</b> As a patient you have the option to appoint a representative to serve as your health care representative pursuant to IC 16-36-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the IDOH web site at <a href="https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/">https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                             |                                                                                 |