FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

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)

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.

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

☐ **Do Not Attempt Resuscitation/DNR (Allow Natural Death) – no resuscitative efforts including artificial stimulation of the cardiopulmonary system 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:** Includes intensive care. Use intubation, advanced airway interventions, mechanical ventilation, cardioversion, medical treatment, IV fluids as indicated; provide comfort measures. **Transfer to hospital, if indicated.**

☐ **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. Generally avoid intensive care.**

☐ **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. **Do NOT transfer to hospital, unless comfort needs cannot be met in current location.**

Additional Orders: _____

C Check One Box Only

MEDICALLY ASSISTED NUTRITION: Always offer food / fluids by mouth if feasible

☐ Insert a feeding tube long-term if indicated
☐ Insert a feeding tube for a defined trial period
☐ 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 parent or adult child
☐ Patient's grandparent, adult sibling or adult grandchild
☐ Other (explain): _____

Physician Signature	**Date**	**Physician Name (type or print)**	**Phone #**

Signature of Person, Guardian, Healthcare Agent, Surrogate or Spouse

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. 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 #
Patient or Representative Name (Print)		Relationship

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SC COALITION FOR THE CARE of the Seriously Ill

Pilot Project Form #_____

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If another person assists in completion of form: **Patient Last Name** _____

NAME OF Person Preparing Form	Title of Preparer	Phone #	Date

Indications for Use

These are physician orders based upon a patient's wishes concerning care at the end of life. The form is for persons eighteen years or older with an incurable or irreversible condition diagnosed by a healthcare provider that within his/her reasonable medical judgment could cause death within a reasonably short period of time if life sustaining procedures are not used.

Instructions for Use

In any emergency situation, POST orders 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 view these orders as a valid expression of patient wishes until the contents are reviewed with the patient or, if the patient is unable, the legally authorized representative at the earliest available opportunity. **The physician should document review of the POST and conversations about the POST in the medical record.**

Directions for Completing POST Form

POST must be prepared based on patient preferences and medical indications.

POST is a medical order and must be reviewed and signed by a licensed physician (MD/DO) to be valid.

Document the basis for the order 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 original form and registry forms are valid.

Section A: Selecting "Attempt Resuscitation/CPR" requires choosing "Full Treatment" in Section B

Section B: If "Comfort Measures" is selected, hospice referral is recommended.
Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP) and bag valve mask (BVM) assisted respirations.

POST is part of advance care planning, which also may include a Living Will and Healthcare Power of Attorney (HCPOA). If there is a Living Will, HCPOA or other advance directive, a copy should be attached if available.

There is no requirement that a patient have a POST.

Reviewing POST:

POST may be reviewed whenever:
- the patient is admitted and/or discharged from any healthcare facility; or
- the patient's health status substantially changes; or
- the patient's treatment preferences change.

Modifying and Voiding POST:

- A patient or, if unable, the legally authorized representative (LAR) may change his/her mind about treatment preferences, void the POST form and complete a new POST form at any time, if desired. To void POST, draw a line from Section A through Section D and write "VOID" in large letters. Sign and date this line.
- **POST MAY BE REVOKED BY ORAL OR WRITTEN STATEMENT BY THE PATIENT OR LAR TO HEALTHCARE PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.**

POST Repository Pilot

SC Coalition for Care of Seriously Ill (SCC CSI) is piloting this form in the Charleston and Greenville areas of 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.

Fax to Roper St. Francis at 843-724-1961 – Attention POST Repository