

## Directions for Health Care Professionals

### Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid. POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

### Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

### Reviewing POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

**COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.**



**A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED**

**Tennessee Physician Orders for Scope of Treatment (POST, sometime called "POLST")**

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

**Section A**  
*Check One Box Only*

**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.**

- Resuscitate (CPR)**                       **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C, and D.**

**Section B**

*Check One Box Only*

**MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.**

- Comfort Measures.** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**
- Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: basic medical treatment.**
- Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions mechanical ventilation as indicated. **Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:* \_\_\_\_\_

**Section C**

*Check One*

**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.**

- No artificial nutrition by tube.  
 Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.

*Other Instructions:* \_\_\_\_\_

**Section D**

*Must be Completed*

**Discussed with:**

- Patient/Resident  
 Health care agent  
 Court-appointed guardian  
 Health care surrogate  
 Parent of minor  
 Other: \_\_\_\_\_ (Specify)

**The Basis for These Orders Is: (Must be completed)**

- Patient's preferences  
 Patient's best interest (patient lacks capacity or preferences unknown)  
 Medical indications  
 (Other) \_\_\_\_\_

Physician/NP/CNS/PA Name (Print)	Physician/NP/CNS/PA Signature	Date	MD/NP/CNS/PA Phone Number:
	NP/CNS/PA (Signature at Discharge)		( )

**Signature of Patient, Parent of Minor, or Guardian/Health Care Representative**

**Preferences have been expressed to a physician and /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.**

Name (Print)	Signature	Relationship (write "self" if patient)	
Agent/Surrogate	Relationship	Phone Number ( )	
Health Care Professional Preparing Form	Preparer Title	Phone Number ( )	Date Prepared

