# LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT

# (LaPOST)

**FIRST** follow these orders, **THEN** contact physician. This is a Physician Order Sheet based on the person's medical condition and wishes. Any Section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect. Please see www.La-POST.org for information regarding "what my cultural/religious heritage tells me about end of life care"

LAST NAME

FIRST/MIDDLE INITIAL

DATE OF BIRTH

**PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:**

Check One

**A. CARDIOPULMONARY RESUSCITATION (CPR):** PERSON HAS NO PULSE AND IS NOT BREATHING

☐ CPR/Attempt Resuscitation (requires full treatment in section B)

☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

Check One

**B. MEDICAL INTERVENTIONS:** PERSON HAS PULSE OR IS BREATHING

☐ COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer: EMS contact medical control to determine if transport indicated.*

☐ LIMITED ADDITIONAL INTERVENTIONS: Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubations, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care unit if possible.

☐ FULL TREATMENT: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation. Transfer to hospital if indicated, Includes intensive care unit.

ADDITIONAL ORDERS: *(e.g. dialysis, etc.)*

Check One

**C. ANTIBIOTICS**

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics if life can be prolonged.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal. (Benefit of treatment should outweigh burden of treatment)

ADDITIONAL ORDERS:

The administration of nutrition and hydration, whether orally or by invasive means, shall always occur except in the event another condition arises, which is life-limiting or irreversible in which the nutrition or hydration becomes a greater burden than benefit to Patient.

Check One in Each Column

**D. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:** **(Always offer food/fluids by mouth as tolerated)**

☐ No artificial nutrition by tube.

☐ Trial period of artificial nutrition by tube (Goal :_____)

☐ Long-term artificial nutrition by tube. (If needed)

☐ IV fluids (Goal :_____)

☐ No IV fluids

ADDITIONAL ORDERS:

**E. OTHER INSTRUCTIONS:** (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)

Check One

**F. SUMMARY OF GOALS:**

**DISCUSSED WITH:** ☐ Patient ☐ Personal Health Care Representative

Check All That Apply

**The basis for these orders is:**

☐ Patient's declaration (can be oral or nonverbal)

☐ Patient's Personal Health Care Representative (Qualified Patient without capacity)

☐ Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.

☐ Resuscitation would be medically non-beneficial.

**PRINT PHYSICIAN'S NAME** | **PHYSICIAN SIGNATURE (MANDATORY)** | **PHONE NUMBER**

**PATIENT OR PERSONAL HEALTH CARE REPRESENTATIVE SIGNATURE (MANDATORY)** | **DATE**

**If Personal Health Care Representative, state relationship and authority to act on behalf of patient:**

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

# DIRECTIONS FOR HEALTH CARE PROFESSIONALS

### COMPLETING LaPOST

- Must be completed by a physician based on patient preferences and medical indications.
- **LaPOST** must be signed by a physician to be valid. Verbal physician orders are acceptable with follow-up signature by physician in accordance with Louisiana law.
- Use of original form is strongly encouraged. Photocopies and faxes of signed **LaPOST** are legal and valid.

### USING LaPOST

- Any section of **LaPOST** not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation".
- Even if a patient chooses "no artificial nutrition by tube" or "no IV fluids" or "trial period of artificial nutrition by tube," the administration of nutrition and hydration, whether orally or by invasive means, shall always occur except in the event another condition arises which is life limiting and irreversible in which nutrition and hydration by any means becomes a greater burden than benefit to Patient.
- 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. pinning of a hip fracture).
- A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
- A parenteral (IV/Subcutaneous) medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity or the personal representative (if the patient lacks capacity) can revoke the **LaPOST** at any time and request alternative treatment based on the known desires of the individual or, if unknown, the individual's best interests.
- Please see links on www.La-POST.org for "what my cultural/religious heritage tells me about end of life care"

**The duty of medicine is to care for patients even when they cannot be cured. Physicians and their patients must evaluate the use of technology available for their personal medical situation. Moral judgments about the use of technology to maintain life must reflect the inherent dignity of human life and the purpose of medical care.**

### REVIEWING LaPOST

This **LaPOST** should be reviewed periodically such as when the person is transferred from one care setting or care level to another, or there is a substantial change in the person's health status, . A new **LaPOST** should be completed if the patient wishes to make a substantive change to their treatment goal (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical chart.

To void the **LaPOST** form, draw line through "Physician Orders" and write "VOID" in large letters. This should be signed and dated.

## REVIEW OF THIS LaPOST FORM

| REVIEW DATE AND TIME | REVIEWER | LOCATION OF REVIEW | REVIEW OUTCOME |
|---|---|---|---|
| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |
| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |
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| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.