HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.	
Address	
City / State / Zip	
Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN ☐☐☐☐

A ✓one only

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

☐ Attempt Resuscitation ☐ Do Not Attempt Resuscitation (DNR/No CPR)

When Do Not Attempt Resuscitation is checked, qualified healthcare personnel are authorized to honor this order as if it were a Durable DNR Order.

When not in cardiopulmonary arrest, follow orders in B & C

B ✓one only

Comfort Measures are always provided, regardless of the level of care chosen

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

☐ **Comfort Measures:** Treat with dignity and respect. Keep 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. Transfer to hospital *only* if comfort needs cannot be met in current location. Also see "Other Instructions" if indicated below.

☐ **Limited Additional Interventions:** Includes comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Transfer to hospital if indicated. Avoid intensive care unit. Also see "Other Instructions" if indicated below.

☐ **Full Interventions:** In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Instructions" if indicated below.

Other Instructions: _____

C ✓one only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if feasible.

☐ **NO** feeding tube (Not consistent with patient's goals given current medical condition)

☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)

☐ Feeding tube long-term if indicated

Other Instructions: _____

DISCUSSED WITH:

☐ Patient ☐ Agent under Advance Medical Directive ☐ Court Appointed Guardian ☐ Other person legally authorized

PHYSICIAN: My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment, to the best of my knowledge.

Physician Name (Print) (Mandatory)	Physician Phone (Mandatory)
Physician Signature (Mandatory)	Date (Mandatory)

Signature of the Patient OR the Person Legally Authorized to Consent on Patient's Behalf (Mandatory)

Patient's Signature	Patient's Name (Print)
Signature of Person Signing on Behalf of the Patient	Name of Person Signing on Behalf of the Patient
Describe Authority to Sign for Patient (Medical Power of Attorney, Guardian, Spouse, Adult Child, Parent, Sibling, Other Blood Relative)	
Phone	Address

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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NAME _____ **LAST 4 SSN** ☐ ☐ ☐ ☐

CARE SETTING OF ORIGIN

☐ Long-Term Care ☐ Hospital ☐ Home ☐ Hospice facility ☐ Outpatient Practice ☐ Other _____

Name of Care Setting: _____

Signature of Healthcare Professional Preparing Form:	Name of Healthcare Professional Preparing Form (Print)	Date Prepared

The intent of this form is to reflect decisions for life-sustaining treatment based on the patient's current medical condition. This form should be reviewed with a treating physician and updated when the patient's medical condition changes, when the patient moves to a new facility or when the patient's preferences change. If a patient is unable to make decisions and is therefore unable to sign this form, the directions on this form should reflect the patient's preferences as best understood by the person authorized to consent under Virginia Law. HIPAA permits disclosure to health care professionals and electronic registry as necessary for treatment.

Directions for Healthcare Professionals

Completing POST

- The orders should reflect patient's current preferences.
- A physician, nurse practitioner or physician assistant who has a bona fide physician/patient relationship with the patient must sign POST. Nurse practitioners and physician assistants are authorized to sign POST forms under the Code of Virginia Sections §64.1-2957.02 and §54.1-2952.2. Health care organizations may have policies that impose limitations on this authority based on their individual scope of practice.
- Use of original form is encouraged. A photocopy, fax or electronic version may be honored as if it were an original.

Using POST

- When comfort cannot be achieved in the current setting, the patient, including someone who has chosen "Comfort Measures," 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 patient who has chosen "Comfort Measures."
- Always offer food and fluids by mouth if medically feasible.

Revoking/Making Changes to POST

- To change POST, the current POST form must be voided and a new POST form completed. If no new form is completed, full treatment and resuscitation may be provided.
- As long as the patient can make his/her own decisions, the patient may revoke consent for POST and may request changes to POST. If a patient tells a healthcare professional that he/she wishes to revoke his/her consent to POST or change POST, the healthcare professional caring for the patient should draw a line through the front of the form and write "VOID" in large letters on the original, with the date and the professional's signature, and notify the patient's physician. A new POST form may then be completed if desired by the patient.
- If not in a healthcare facility, the patient who can make his/her own decisions may revoke consent for POST orders by voiding the form as described above and informing a healthcare professional. The healthcare professional must then notify the patient's physician so that appropriate orders may be written and a new POST form created if desired by the patient.
- If the patient signs this form, the patient's treatment goals should be honored if the patient becomes unable to make decisions, as provided in the Code of Virginia § 54.1-2986.1.
- If the patient is unable to make healthcare decisions, a legally authorized medical decision maker, in consultation with the treating physician, may sign this form, revoke consent to, or request changes to the POST orders to continue carrying out the patient's own preferences in light of changes in the patient's condition.

Persons Legally Authorized to Consent for Patient Incapable of Making an Informed Decision:

An agent named in an Advance Directive (§54.1-2983) may consent for the patient under the terms of the Advance Directive. If the patient has no Advance Directive, the following persons may consent for the patient in this order: guardian, spouse, adult child, parent, adult sibling, other relative in descending order of blood relationship (§54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST forms are available to medical care providers and organizations that have agreed to the standards set forth by the Virginia POST Collaborative. Contact: inquiry@virginiapost.org