HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTHCARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND ORIGINAL WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

IDAHO POST Form: Portable Medical Orders

Health care professionals should only complete this form after a conversation with their patient or the patient's representative. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Note to Patients: Having a POST form is always voluntary.**

This is a medical order, not an advance directive. For information about POST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: IDAHO

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____ ____ ____ ____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse or is not breathing.

Pick 1

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. Requires choosing Full Treatments in Section B)

B. Treatment Orders: Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Full Treatment (required if you choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responders ability to to act on orders in this section]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Not discussed or no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

X *(required)* | Date: *(mm/dd/yyyy):* Required | The most recently completed valid POST form supersedes all previously completed POST forms.

If other than patient, print full name:

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care professional authorized by law to sign POST form in state where completed may sign this order]

X *(required)* | Date: *(mm/dd/yyyy):* Required | Phone Number: ( )

Printed Full Name: | License/Cert. Number

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient's Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact.

(Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone Number: Day: ( ) Night: ( )

Primary Care Provider Name: Phone Number: ( )

☐ Patient is enrolled in hospice

Name of Agency:

Agency Phone Number: ( )

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POST orders:
(A POST form does not replace an advance directive or living will)

- ☐ Yes; date of the document reviewed:_____
- ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)
- ☐ Advance directive not available
- ☐ No advance directive exists

Check everyone who participated in discussion:
☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor
☐ Legal Surrogate / Health Care Agent ☐ Other

Professional Assisting Healthcare Provider w/ Form Completion *(if applicable)* Full Name:	Date: *(dd/mm/yyyy)*	Phone Number: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
- **Using POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.

  Professional Assisting Healthcare Provider w/ Form Completion *(if applicable)*

  Full Name:
- **Modifying POST form:** This form cannot be modified. If changes are needed, void form and complete a new POST form.
- **Voiding a POST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker