Michigan Physician Orders for Scope of Treatment (MI-POST)

First follow these orders, then contact physician. This is a Medical Order Sheet based on the person's medical condition and treatment decisions. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name		
First Name/Middle Initial		
Date of Birth: (mm/dd/yyyy)	Gender: (circle) **M F**	Last 4 SSN:

A

Check one

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

☐ Attempt Resuscitation/CPR ☐ DO NOT Attempt Resuscitation/CPR (DNR/No CPR)

(NOTE: If "Attempt Resuscitation/CPR" is checked in Section A, "Advanced Interventions" must also be checked in Section B.)

B

Check one

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

ALL patients will receive comfort measures.

☐ **Advanced Interventions:** Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated.
Transfer to hospital if indicated; includes intensive care.

☐ **Limited Interventions:** DO NOT use intubation, advanced invasive airway interventions, or mechanical ventilation. Use medical treatment, IV fluids and cardiac monitor as indicated.
Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction manual treatment of airway obstruction and non-invasive respiratory assistance as needed for comfort.
Only transfer to hospital if comfort needs cannot be met in current location.

Additional orders: _____

C

Check one

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

☐ Long-term artificial nutrition

☐ Defined trial period of artificial nutrition

☐ No artificial nutrition

Additional orders: _____

D

DOCUMENTATION OF DISCUSSION

Discussed with:		Patient Goals:
☐ Patient	☐ Court-appointed Guardian	
☐ Patient Advocate (DPOAH)	☐ Other Authorized Representative (specify): _____	

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

My signature below indicates to the best of my knowledge that the orders are consistent with the patient's medical condition and goals of care.

Signature (mandatory)	Phone Number	
Name (print/type)	Date (mm/dd/yyyy)	Time

COMPLETE BELOW IF SIGNED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

Name of Physician of contract:	Physician Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Last Name:	Patient First Name:

E SIGNATURES

☐ Patient
☐ Patient Advocate (DPOAH)
☐ Court-appointed Guardian
☐ Other Authorized Representative (specify): _____

Print Name	Signature	Date (mm/dd/yyyy)
Address	Phone Number	Alternate Phone Number

The patient and/or the patient's authorized representative may revoke these directions at any time.

Witness (1) Signature:	Print Name
Witness (2) Signature :	Print Name

F HEALTHCARE PROVIDERS ASSISTING WITH COMPLETION OF POST FORM

Preparer's Name (print)	Preparer's Signature	Date (mm/dd/yyyy)

HOW TO CHANGE THIS FORM

The POST form should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or care level to another;
- There is a substantial change in patient/resident health status such as:
  - Improved Condition
  - Advanced Progressive Illness
  - Extraordinary Suffering
  - Permanent Unconsciousness
  - Close to death
- The patient's/resident's treatment decisions change.

If this form is revoked, write "VOID" on both sides in large letters, then sign and initial the form. After voiding the form, a new form may be completed. ***If no new form is completed, full treatment and resuscitation shall be provided.***

G REVIEW OF THIS POST FORM

Date	Reviewer Name	Location of Review	Outcome of Review
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- POST must be completed by a healthcare professional based on patient decisions and medical indications.
- POST must be signed in Sections D and E to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility policy, OR
  - A Physician's Assistant or Nurse Practitioner may sign the POST if working under the direction of a physician.
- Use of original forms is strongly encouraged. Photocopies, electronic forms, and faxes of signed POST form are valid.
- POST should be kept in a visible and accessible location.
- Healthcare providers should maintain a copy of the POST in the patient's chart.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY