SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

South Carolina
Physician Orders for Scope of Treatment (POST)

Patient Last Name:	**Patient First Name/MI:**
Patient Date of Birth: (MM/DD/YYYY)	**Patient/Legal Representative Phone Number:**
Social Security Number last 4 digits: (*Optional)* XXX-XX-	**Gender:** ☐ **M** ☐ **F** ☐ **Other**
Patient Mailing Address: (street/city/state/zip)	
Patient's Diagnosis:	

Section A
Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Unresponsive, pulseless, & not breathing.

☐ **Attempt Resuscitation/CPR** (Selecting CPR requires Full Treatment in Section **B**.)

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

If patient is not in cardiopulmonary arrest, follow orders in **B**, **C** and **D.**

Section B
Check One Box Only

MEDICAL INTERVENTIONS: If patient has pulse and/or is breathing.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer to hospital and/or intensive care unit if indicated.***
Treatment Plan: All treatments including breathing machine.

☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airways interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital, if indicated. Avoid ICU if possible.***
Treatment Plan: Provide basic medical treatments.

☐ **Comfort Measures Only.** Keep clean, warm and dry. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort**.** ***Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.***
Treatment Plan: Provide treatments for comfort through symptom management.

Additional Orders:

Section C
Check One Box Only

ANTIBIOTICS

☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ No antibiotics except for relief of pain and discomfort.

Additional Orders:

Section D
Check One Box in Each Column

ARTIFICIALLY ADMINISTERED NUTRITION AND FLUIDS: Offer food and fluids by mouth if feasible.

☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Do not insert feeding tube.	☐ No IV fluids.
☐ Decide when/if the situation arises.	☐ Decide when/if the situation arises.
Additional Orders:	**Additional Orders:**

Section E
Signature of Physician, APRN, or PA

Signature of Physician, Advanced Practice Registered Nurse, or Physician Assistant

My signature below indicates to the best of my knowledge that the patient has been diagnosed with a serious illness or, based upon a medical diagnosis, may be expected to lose capacity within 12 months, and that these orders are consistent with the patient's medical condition, diagnosis, and preferences.

Physician/APRN/PA Signature: *(required)*	Physician/APRN/PA Name: *(print)*	☐ Physician ☐ APRN ☐ PA (*Select one*)
Date: (MM/DD/YYYY) (*required)*	Physician/APRN/PA Phone Number:	Physician/APRN/PA License #:

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Legal Representative ☐ Other:

Section F
Signature of Patient or Legal Representative

Signature of Patient or Legal Representative

I am aware that this form is voluntary. I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician, physician assistant, or advanced practice registered nurse and this document reflects those treatment preferences. *If signed by a legal representative, preferences expressed must reflect patient's wishes as best understood by the legal representative.*

Signature: *(required)*		Relationship: (*write "self" if patient)*
Print Name:	Date: (MM/DD/YYYY) (*required*)	Phone Number:

Section G
Facilitator (if applicable)

Facilitator Assisting with POST Form Completion (if applicable)

Print Name:	Date: (MM/DD/YYYY)	Phone Number:

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST Form	****ATTACH to Page 1****
Patient Full Name:	

Form Completion Information (Optional but Helpful)	
Reviewed patient's advance directive to confirm no conflict with POST form: (A POST form does not replace an advance directive such as a Health Care Power of Attorney 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

- A POST form is a designated document designed for use as part of advance care planning, the use of which must be limited to situations where the patient has been diagnosed with a serious illness or, based upon medical diagnosis, may be expected to lose capacity within 12 months and consists of a set of medical orders signed by a patient's physician, APRN, or PA addressing key medical decisions consistent with patient goals of care concerning treatment at the end of life that is portable and valid across health care settings.
- A POST form executed in South Carolina as provided in the POST Act, or a similar form executed in another jurisdiction in compliance with the laws of that jurisdiction, must be deemed a valid expression of a patient's wishes as to health care. A South Carolina health care provider or health care facility may accept a properly executed POST form as a valid expression of whether the patient consents to the provision of health care in accordance with Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- The effective date of the form is the date the POST form has been completed, executed, and signed by the Physician/APRN/PA and the patient or the patient's legal representative.
- A copy, facsimile, or electronic version of a completed POST form is considered to be legal.
- **The execution of a POST form is always voluntary and is for a person with an advanced illness.** The POST form records a patient's wishes for medical treatment in the patient's current state of health. Preferred medical treatment as stated by the patient on the POST form may be changed at any time by the patient or a designated health care representative or health care agent of the patient to reflect the patient's new wishes in accordance with the POST Act.
- Any physician who is responsible for the creation and execution of a POST form shall make reasonable efforts to periodically review and update the POST form with the patient as the patient's needs dictate but at least once per year.
- A patient's legal representative is defined under the POST Act to mean a person with priority to make health care decisions for patient pursuant to Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- An APRN may create, execute and sign a POST form if authorized to do so by his or her practice agreement. The POST form must be for a patient of the APRN, the physician with whom the APRN has entered into a practice agreement, or both.
- A PA may create, execute, and sign a POST form if authorized to do so by his or her scope of practice guidelines. The POST form must be for a patient of that PA, the PA's supervising physician, or both.

Revocation of POST Form

- A POST form may be revoked at any time by an oral or written statement by the patient or a patient's legal representative.
- A revocation is only effective upon communication to the health care provider or health care facility by the patient or the patient's legal representative.
- The execution of a POST form by a patient, or the patient's legal representative, pursuant to the POST Act, automatically revokes any previously executed POST form.
- A POST form executed pursuant to the POST Act remains effective until revoked or until a new POST form is executed pursuant to the POST Act.

Nothing herein shall be construed as legal advice.

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED