# 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 ☐ Court-appointed Guardian

☐ Patient Advocate (DPOAH) ☐ Other Authorized Representative (specify): _____

Patient Goals:

**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 ☐ Court-appointed Guardian
☐ Patient Advocate (DPOAH) ☐ 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<br>☐ Form voided ☐ New Form completed |
| | | | ☐ No change<br>☐ Form voided ☐ New Form completed |
| | | | ☐ No change<br>☐ Form voided ☐ New Form completed |
| | | | ☐ No change<br>☐ Form voided ☐ New Form completed |
| | | | ☐ No change<br>☐ Form voided ☐ New Form completed |
| | | | ☐ No change<br>☐ 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**