MISSISSIPPI PHYSICIAN ORDERS FOR SUSTAINING TREATMENT (POST)

- This document is based on this person's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either
- HIPAA permits disclosure of POST to other health professionals as necessary
- Any section not completed indicates preference for full treatment for that section

Patient Last Name	Patient First Name/Middle
Patient Date of Birth	Effective Date (Form must be reviewed at least annually)

A Check one

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

- ☐ Attempt Resuscitation (CPR)
- ☐ Do Not Attempt Resuscitation (DNR)

*When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.*

B Check One

MEDICAL INTERVENTIONS: If the patient has pulse AND breathing OR has pulse and is NOT breathing.

- ☐ **Full Sustaining Treatment:** Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures. Provide treatment including the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, intravenous fluids, and comfort measures.
- ☐ **Limited Interventions:** Transfer to a hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments. In addition to care described in Comfort Measures below, provide the use of medical treatment; oral and intravenous medications; intravenous fluids; cardiac monitoring as indicated; noninvasive bi-level positive airway pressure; a bag valve mask. This option excludes the use of intubation or mechanical ventilation.
  ADDITIONAL ORDERS: (e.g., vasopressors, dialysis, etc.)_____
- ☐ **Comfort Measures Only**: Treatment Goal: Maximize comfort through use of medication by any route; keeping the patient clean, warm, and dry; positioning, wound care, and other measures to relieve pain and suffering; and the use of oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to a hospital unless comfort needs cannot be met in the patient's current location (e.g., hip fracture).
  Other instructions:_____

C Check One

ANTIBIOTICS:

- ☐ Use antibiotics if life can be sustained
- ☐ Determine use or limitation of antibiotics when infection occurs
- ☐ Use antibiotics only to relieve pain and discomfort

Other Instructions_____

D Check One in Each of the 3 Categories

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Administer oral fluids and nutrition if physically possible.

Directing the administration of nutrition into blood vessels if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:

- ☐ Total parenteral nutrition, long-term if indicated.
- ☐ Total parenteral nutrition for a defined trial period. Goal: _____
- ☐ No parenteral nutrition.

Directing the administration of nutrition by feeding tube if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:

- ☐ Long-term feeding tube if indicated
- ☐ Feeding tube for a defined trial period. Goal: _____
- ☐ No feeding tube

OTHER INSTRUCTIONS _____

Directing the administration of hydration if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following

- ☐ Long-term intravenous fluids if indicated
- ☐ Intravenous fluids for a defined trial period. Goal: _____
- ☐ Intravenous fluids only to relieve pain and discomfort

E Check All That Apply

PATIENT PREFERENCES AS A BASIS FOR THIS POST FORM (*THIS SECTION TO BE FILLED OUT WITH PATIENT DIRECTION*)

- ☐ Patient has an advance healthcare directive (per statute § 41-41-203): ☐ YES , Date of Execution: _____
  I certify that the Physician Order for Sustaining Treatment is in accordance with the advance directive.

Signature:_____ Print Name:_____ Relationship:_____

- ☐ Patient is an unemancipated minor, direction was provided by the following in accordance with §41-41-3, Mississippi Code of 1972:
  - ☐ Minor's guardian or custodian
  - ☐ Minor's parent
  - ☐ Adult brother or sister of the minor
  - ☐ Minor's grandparent, or
  - ☐ Adult who has exhibited special care and concern for minor
- ☐ Patient is an adult or an emancipated minor, direction was provided by the following in accordance with §41-41-205, 41-41-211 or 41-41-213, Mississippi Code of 1972:
  - ☐ Patient

- ☐ Agent authorized by patient's power of attorney for health care
- ☐ Guardian of the patient
- ☐ Surrogate designated by patient
- ☐ Spouse of patient (if not legally separated)
- ☐ Adult child of the patient
- ☐ Parent of the patient
- ☐ Adult brother or sister of the patient, or
- ☐ Adult who has exhibited special care and concern for the patient and is familiar with the patient's values

F

SIGNATURE OF PATIENT OR REPRESENTATIVE

Signature	Print Name	Date

SIGNATURE OF PRIMARY PHYSICIAN (POST MUST BE REVIEWED AND SIGNED BY A PHYSICIAN TO BE VALID)

Signature (**Required**)	Print Name	Date (**Required**)

HEALTH CARE PROFESSIONAL PREPARING FORM (IF OTHER THAN PATIENT'S PRIMARY PHYSICIAN)

Signature	Print Name	Contact Information	Date

G

INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

The POST form is always voluntary and is usually for persons with advanced illness. POST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance health-care directive is recommended for all capable adults and emancipated minors, regardless of their health status. An advance directive allows you to document in detail your future health care instructions and/or name a health-care agent to speak for you if you are unable to speak for yourself.

If this form is for a minor for whom you are authorized to make health-care decisions, you may not direct denial of medical treatment in a manner that would make the minor a "neglected child" under Section 43-21-105, Mississippi Code of 1972, or otherwise violate the child abuse and neglect laws of Mississippi. In particular, you may not direct the withholding of medically indicated treatment from a disabled infant with life-threatening conditions, as those terms are defined in 42 USCS Section5106g or regulations implementing it and 42 USCS Section 5106a.

H

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

I. COMPLETING POST

POST must be reviewed and prepared in consultation with the patient or the patient's representative.

POST must be reviewed and signed by a physician to be valid. Be sure to document the basis for concluding the patient had or lacked capacity at the time of execution on the form in the patient's medical record. The signature of the patient or the patient's representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature on this form.

Use of original form is required. Be sure to send the original form with the patient.

There is no requirement that a patient have a POST.

II. IMPLEMENTING POST

If a health care provider or facility is unwilling to comply with the orders due to policy or personal objections, the provider or facility must not impede transfer of the patient to another provider or facility willing to implement the orders and must provide at least requested care in the meantime unless, in reasonable medical judgment, denial of requested care would not result in or hasten the patient's death.

If a minor protests a directive to deny the minor life-preserving medical treatment, the denial of treatment may not be implemented pending issuance of a judicial order resolving the conflict.

III. REVIEWING POST

This POST must be reviewed at least annually or earlier if;

a. The patient is admitted or discharged from a health care facility;
b. There is a substantial change in the patient's health status; or
c. The patient's treatment preferences change

If POST is revised or becomes invalid, draw a line through Sections A-E and write "VOID" in large letters.

IV. REVOCATION OF POST

This POST may be revoked by the patient or the patient's representative.

I

REVIEW OF POST

Review Date	Reviewer and Location of Review	MD/DO Signature (Required)	Signature of Patient or Representative (Required)	Outcome of Review (Choose one)
				☐ No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐ No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form