Date:_____

VERIFICATION OF DO NOT RESUSCITATE ORDER

Dear Physician:

Please complete this card and with the permission of the patient, FAX the entire card to the WV e-Directive Registry, then detach at the perforation, give the bottom of the card to the patient, and keep the top in your records.

REGISTRY FAX: 304-293-7442

Last Name/First/Middle Initial (Print clearly)

_____

Address:

_____

City/State/Zip:

_____

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

☐☐☐☐

Gender

☐ M ☐ F

Date:_____

DO NOT RESUSCITATE ORDER

As treating physician of _____

(patient name)

and a licensed physician, I order that this person **SHALL NOT BE RESUSCITATED** in the event of cardiac or respiratory arrest. This order has been discussed with _____

or his/her representative _____

or his/her surrogate decision maker _____

who has given consent as evidenced by his/her signature below.

Physician Full Name (Printed) _____

Physician Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

☐☐☐☐

Gender

☐ M ☐ F

If you cancel this DNR Card,
CALL the WV e-Directive Registry at
877-209-8086
so that it can be removed from the Registry.

For more information or additional cards, please contact:

WV Center for End-of-Life Care
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022

877-209-8086
www.wvendoflife.org

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

West Virginia Physician Orders
for Scope of Treatment (POST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Last Name/First/Middle Initial		
Address		
City/State/Zip		
Date of Birth (mm/dd/yyyy) ____/____/____	Last 4 SSN ☐☐☐☐	Gender ☐M ☐F

A *Check One Box Only*

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

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

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

B *Check One Box Only*

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

☐ **Comfort Measures** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care unit.**

☐ **Full Interventions** Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care unit.**

Other Orders: _____

C *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Oral fluids and nutrition must be offered as tolerated.

☐ **No IV fluids** (provide other measures to assure comfort)	☐ **No feeding tube**
☐ **IV fluids for a trial period of no longer than** _____	☐ **Feeding tube for a trial period of no longer than** _____
☐ **IV fluids long-term if indicated**	☐ **Feeding tube long-term**

Other Orders: _____

D

Discussed with:

☐ Patient/Resident ☐ Health care surrogate ☐ MPOA representative ☐ Spouse
☐ Court-appointed guardian ☐ Parent of Minor ☐ Other: _____ (Specify)

Authorization **INITIAL BOX** if you agree with the following statement: If I lose decision making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new form with my physician in accordance with my expressed wishes for such a condition or, if these wishes are unknown or not reasonably ascertainable, my best interests.

Registry Opt-In ☐ **INITIAL BOX** if you agree to have your POST form, do not resuscitate card, living will and medical power of attorney form (if completed) submitted to the WV e-Directive Registry and released to treating health care providers. REGISTRY FAX - 304-293-7442

Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)	**Date**

Signature of Physician

Physician Name (Print Full Name)	**Physician Phone Number**
Physician Signature (Mandatory)	**Date and Time**

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

2012 rev

e-Directive Registry FAX 304-293-7442

Last Name/First/Middle Initial

E

Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form

Advance Directive (Living Will or MPOA)	☐ NO	☐ YES - Attach copy
Organ and Tissue Document of Gift	☐ NO	☐ YES - Attach copy of documentation
Court-appointed Guardian	☐ NO	☐ YES - Attach copy of documentation
Health Care Surrogate Selection	☐ NO	☐ YES - Attach copy of documentation

MPOA/Surrogate/Court-appointed Guardian/Parent of Minor Contact Information

Name	Address	Phone

Person Preparing Form

Signature of Person Preparing Form	Preparer Name (Print)	Date Prepared

F

Review of this POST Form

Date of Review	Reviewer	Physician Signature	Location of Review	Outcome of Review
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, **no** new form

Review of POST Form

This form should be reviewed if there is substantial change in patient/resident health status or patient/resident treatment preferences. According to state law, the form must be reviewed if the patient/resident is transferred from one health care setting to another. If this form is to be voided, write the word "VOID" in large letters on the front of the form. After voiding the form, a new form may be completed. *If no new form is completed, note that full treatment and resuscitation may be provided.* FAX voided form and newly completed form to the Registry. Additional forms can be obtained by calling 877-209-8086 or ordered online from the WV Center for End-of-Life Care website at www.wvendoflife.org/Request-Information.

Instructions for Submission to the WV e-Directive Registry (if Opt-In Box is initialed)

FAX a copy of BOTH sides of the POST form to the e-Directive Registry at 304-293-7442. Copy form on your copy machine and adjust the lightness/darkness to contrast depending on your machine so that the form is readable prior to FAXing to the Registry. If you have questions about submission of this POST form or other advance directive documents to the Registry, call 877-209-8086. If you are using POST forms that were printed prior to 2010 and wish to submit them to the Registry, please complete a Sign-Up Form that contains the additional demographic information needed to identify the patient/resident in the Registry. The Sign-Up Form can be downloaded at www.wvendoflife.org/e-Directive-Registry.

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED