HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Iowa Physician Orders for Scope of Treatment (IPOST)

First follow these orders, **THEN** contact physician or nurse practitioner. This is a Physician order sheet based on the person's current medical condition and wishes. Any **section not completed implies full treatment for that section.** Everyone shall be treated with dignity and respect.

Last Name

First/Middle Name

Date of Birth

A Check one

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

☐ CPR/Attempt Resuscitation

☐ DNR/Do Not Attempt Resuscitation

B Check one

MEDICAL INTERVENTIONS: Person has a pulse **AND/OR** is breathing.

☐ **COMFORT MEASURES ONLY** 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. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. **Do not** use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. ***Transfer*** *to hospital if indicated, may include critical care.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes critical care.*

Additional Orders: _____

C Check one

ARTIFICIALLY ADMINISTERED NUTRITION Always offer food by mouth if feasible.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

D

MEDICAL DECISION MAKING

Directed by: (listed in order of Iowa Code/Statute for Priority of Surrogates; check only one)

☐ Patient

☐ Durable Power of Attorney for Health Care

☐ Spouse

☐ Majority of Adult Children

☐ Parents

☐ Majority rule for nearest relative

☐ Other: _____

Rationale for these orders: (check all that apply)

☐ Advance Directives
Year AD completed: _____

☐ Patient's known preference

☐ Limited treatment options

☐ Poor prognosis

☐ Other: _____

Print Physician/ARNP/ Name	Physician/ARNP/signature (mandatory)	Phone Number

Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)	Date

Validated By (must not be a member of physician's staff):	Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and Faxes of signed IPOST forms are legal and valid

HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Information for Person named on this Form **Person's Name** (print) _____

This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate

Signature	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate (optional)	Relationship	Phone Number	Address

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions For Health Care Professionals

Completing IPOST

- Must be completed by a health care professional based on patient preferences and medical indications.
- IPOST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed IPOST forms are legal and valid.

Using IPOST

- Any section of IPOST not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Deactivate internal defibrillators if comfort measures only are in effect.
- Medications by alternative routes of administration to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Reviewing IPOST

- This IPOST should be reviewed periodically and a new IPOST completed when the person's treatment preferences change. Review may also occur when the person is transferred from one care setting or care level to another.

Voiding IPOST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through C and write "VOID" in large letters if IPOST is replaced or becomes invalid.

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED

Revised 01/21/09, 1/30/09,05/27/09