West Virginia POST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

West Virginia POST Form

Adapted from the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Health care providers should complete this form only after a conversation with the patient or the patient's Medical Power of Attorney (MPOA) representative or surrogate. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. https://polst.org/guidance-appropriate-patients-pdf

Patient Information. **Having a POST form is always voluntary.**

THIS IS A MEDICAL ORDER, NOT AN ADVANCE DIRECTIVE.
Review and revise advance directives to be consistent with POST.

Patient First Name:_____ Middle Initial:_____

Last Name:_____ Suffix (Jr, Sr, etc): _____

Preferred Name:_____ DOB (mm/dd/yyyy): _____/_____/_____

Last 4 Social Security Number: xxx-xx-_____ _____ _____ _____ Gender (circle one): M F X

Address: _____ Zip code: _____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.
(Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation.
(May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and is breathing.

Reassess and discuss interventions with patient or MPOA representative/surrogate regularly to ensure treatments are meeting patient's care goals. Consider a time-limited trial of interventions based on goals.

Pick 1

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
EMS protocols may limit emergency responder ability to act on orders in this section.

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe, and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Time-limited trial of _____ days but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Discussed but no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative/Surrogate/Guardian (eSigned documents are valid)

Authorization ☐	Indicate in this 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 POST form in accordance with my expressed wishes for such a condition or if these wishes are unknown or not reasonably ascertainable, my best interests.
Opt-In ☐	Indicate in this box if you agree to have your POST and other forms submitted to the WV e-Directive Registry and released to treating health care providers to ensure your wishes are known. **FAX 844-616-1415**

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's MPOA representative/surrogate, the treatments are consistent with the patient's expressed wishes or, if unknown, their best interests.

Patient/Patient MPOA representative/surrogate signature (required)	Date (mm/dd/yyyy)	The most recently completed, valid POST form supersedes all previously completed POST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or the patient's MPOA representative/surrogate. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only providers with MD, DO, APRN, or PA license may sign this order]

MD/DO/APRN/PA signature (required)	Date (mm/dd/yyyy): Required / /	Phone # :
Printed Full Name: required		License/Cert. #:

Send original form with patient. A copied, faxed, or electronic version of this form is a valid medical order. This form does not expire.
WV Center for End-of-Life Care: 1-877-209-8086. **WV e-Directive Registry FAX: 844-616-1415**

West Virginia POST
Physician Orders for Scope of Treatment
A Participating Program of National POLST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

WV POST form: A Portable Medical Order

Consistent with the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Patient Full Name:

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative.)

Full Name:	☐ MPOA Representative/surrogate ☐ Other emergency contact	Phone #:

Primary Care Provider Name: Phone: ( )

☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )

Reviewed patient's advance directive to confirm no conflict with POST orders: (A POST form does not replace an advance directive 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

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court-Appointed Guardian ☐ Parent of Minor ☐ MPOA representative/Surrogate ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - MPOA representative/surrogate may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
  - **FAX completed form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Using a POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care, and other measures to relieve pain and suffering.
- **Reviewing a POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes their treatment preferences or goals of care.
- **Modifying a POST form:** This form cannot be modified. If changes are needed, void form (see below) and complete a new POST form. **FAX new POST form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Voiding a POST form:**
  - **If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.
  - **For health care providers**: destroy copy (if possible), note in patient record form is voided and notify the WV e-Directive Registry.
  - *If no new form is completed, note that full treatment and resuscitation may be provided.*
- **Additional Forms.** Can be obtained by going to www.wvendoflife.org/ or by calling 877-209-8086.
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.
- **Submitting a POST form (or any form) to the WV e-Directive Registry (if Opt-In Box is initialed)**
  - With the permission of patients or their legal agents, the WV e-Directive Registry houses and makes available to treating health care providers advance directive forms, do not resuscitate (DNR) cards, Physician Orders for Scope of Treatment (POST) forms, etc. The Registry makes patients' treatment wishes known to their physicians so that they can be respected. By submitting forms to the e-Directive Registry, the patient can ensure their forms are available in the event of a health care emergency in order for medical wishes to be translated into patient care. More information is available at www.wvendoflife.org/wv-e-directive-registry. FAX a copy of the POST form to the WV e-Directive Registry at 844-616-1415. Ensure the form is readable prior to faxing the form to the Registry. For questions, call 877-209-8086.