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 the physician, nurse practitioner or physician's assistant. This is a medical order sheet based on the person's current medical condition and treatment preferences. 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
- ☐ Patient's known preference
- ☐ Limited treatment options
- ☐ Poor prognosis
- ☐ Other: ______________________

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

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

SEND IPOST WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON

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 treatment preferences as best understood by your surrogate.

Contact Information

Surrogate (optional)	Relationship	Phone Number

Directions For Health Care Professionals

Completing IPOST

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

Using IPOST

- Any section of the 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" unless otherwise specified.
- Deactivation of 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."

Voiding IPOST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- To void this form, draw line through sections A through C and write "VOID" in large letters across the form and sign and date that line if IPOST is replaced or becomes invalid.
- Any changes require a new IPOST.

Transferring/Discharging with IPOST

- The IPOST form belongs to the person.
- The IPOST form **MUST** accompany the person upon all transfers between care settings.
- Document that the IPOST was sent with the person.
- Recommended use at home: Advise patient they must keep IPOST in easily accessible location that the ambulance service could find if no family or friends present (example may be in an envelope or baggie on the refrigerator).

Reviewing IPOST

- This IPOST should be reviewed periodically whenever:
  1. The person is transferred from one care setting or care level to another, or
  2. There is a substantial change in the person's health status, or
  3. The person's treatment preferences change.

Reviewed by:	Date:	Reviewed by:	Date:	Reviewed by:	Date:

Prepared by:

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED
DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON