### Section A
**CARDIOPULMONARY RESUSCITATION (CPR):** Patient has no pulse and/or is not breathing.
- [ ] Resuscitate (CPR)
- [ ] Do Not Attempt Resuscitate (DNR/no CPR)

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

### Section B
**MEDICAL INTERVENTIONS.** Patient 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, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**

- [ ] Full Treatment.  Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

*Other Instructions:*

### Section C
**ANTIBIOTICS – Treatment for new medical conditions:**
- [ ] No Antibiotics
- [ ] Antibiotics

*Other Instructions:*

### Section D
**MEDICALLY ADMINISTERED FLUIDS AND NUTRITION.** Oral fluids and nutrition must be offered if medically feasible.
- [ ] No IV fluids (provide other measures to assure comfort)
- [ ] IV fluids for a defined trial period
- [ ] IV fluids long-term if indicated

*Other Instructions:*

### Section E
**Discussed with:**
- [ ] Patient/Resident
- [ ] Health care agent
- [ ] Court-appointed guardian
- [ ] Health care surrogate
- [ ] Parent of minor
- [ ] Other: ____________ (Specify)

**The Basis for These Orders Is:**
- [ ] Patient’s preferences
- [ ] Patient’s best interest (patient lacks capacity or preferences unknown)
- [ ] Medical indications
- [ ] (Other) ____________ (Specify)

**Physician Signature** (Mandatory)  **Physician Phone Number**  **Office Use Only**  **Date**
<table>
<thead>
<tr>
<th>Signature of Patient, Parent of Minor, or Guardian/Health Care Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.</td>
</tr>
<tr>
<td>(If signed by surrogate, preferences expressed must reflect patient’s wishes as best understood by surrogate.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name (print)</th>
<th>Relationship (write “self” if patient)</th>
</tr>
</thead>
</table>

**Contact Information**

<table>
<thead>
<tr>
<th>Surrogate</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Care Professional Preparing Form</th>
<th>Preparer Title</th>
<th>Phone Number</th>
<th>Date Prepared</th>
</tr>
</thead>
</table>

**Directions for Health Care Professionals**

**Completing POST**

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

**Using POST**

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen “Do Not Attempt Resuscitation”.

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only”, should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only”.

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment”.

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

**Reviewing POST**

This POST should be reviewed if:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient’s health status, or
3. The patient’s treatment preferences change.

Draw line through sections A through E and write “VOID” in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

DO NOT ALTER THIS FORM!