

## LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

**FIRST** follow these orders, **THEN** contact physician. This is a Physician Order form based on the person's medical condition and preferences. Any section not completed implies full treatment for that section. LaPOST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect. Please see [www.La-POST.org](http://www.La-POST.org) for information regarding "what my cultural/religious heritage tells me about end of life care."

<b>LAST NAME</b>	
<b>FIRST NAME/MIDDLE NAME</b>	
<b>DATE OF BIRTH</b>	<b>MEDICAL RECORD NUMBER (optional)</b>

**PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:**

\_\_\_\_\_

\_\_\_\_\_

**GOALS OF CARE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**A. CARDIOPULMONARY RESUSCITATION (CPR): PERSON IS UNRESPONSIVE, PULSELESS AND IS NOT BREATHING**

CHECK ONE	<input type="checkbox"/> CPR/Attempt Resuscitation (requires full treatment in section B)	When not in cardiopulmonary arrest, follow orders in <b>B</b> and <b>C</b> .
	<input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death)	

**B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING**

CHECK ONE	<input type="checkbox"/> <b>FULL TREATMENT</b> (primary goal of prolonging life by all medically effective means) Use treatments in Selective Treatment and Comfort Focused treatment. Use mechanical ventilation, advanced airway interventions and cardioversion if indicated.
	<input type="checkbox"/> <b>SELECTIVE TREATMENT</b> (primary goal of treating medical conditions while avoiding burdensome treatments) Use treatments in Comfort Focused treatment. Use medical treatment, including antibiotics and IV fluids as indicated. May use non invasive positive airway pressure (CPAP/BiPAP). Do not intubate. Generally avoid intensive care.
	<input type="checkbox"/> <b>COMFORT FOCUSED TREATMENT</b> (primary goal is maximizing comfort) Use medication by any route to provide pain and symptom management. Use oxygen, suctioning and manual treatment of airway obstruction as needed to relieve symptoms. (Do not use treatments listed in full or selective treatment unless consistent with goals of care. Transfer to hospital ONLY if comfort focused treatment cannot be provided in current setting.)

ADDITIONAL ORDERS: (e.g. dialysis, etc.)

\_\_\_\_\_

\_\_\_\_\_

Medically assisted nutrition and hydration is optional when it

- cannot reasonably be expected to prolong life
- would be more burdensome than beneficial
- would cause significant physical discomfort

**C. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (Always offer food/fluids by mouth as tolerated)**

CHECK ONE	<input type="checkbox"/> No artificial nutrition by tube.
	<input type="checkbox"/> Trial period of artificial nutrition by tube. (Goal: _____)
	<input type="checkbox"/> Long-term artificial nutrition by tube. (If needed)

**D. SUMMARY**

<b>Discussed with:</b> <input type="checkbox"/> Patient (Patient has capacity) <input type="checkbox"/> Personal Health Care Representative (PHCR)	
<b>The basis for these orders is:</b>	
CHECK ALL THAT APPLY	<input type="checkbox"/> Patient's declaration (can be oral or nonverbal)
	<input type="checkbox"/> Patient's Personal Health Care Representative (Qualified Patient without capacity)
	<input type="checkbox"/> Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.
	<input type="checkbox"/> Resuscitation would be medically non-beneficial.
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed
	<input type="checkbox"/> Advance Directive not available
	<input type="checkbox"/> No Advance Directive
	<input type="checkbox"/> Health care agent if named in Advance Directive:
	Name: _____
	Phone: _____

This form is voluntary and the signatures below indicate that the physician orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interest of the patient who is the subject of the document.

PRINT PHYSICIAN'S NAME	PHYSICIAN SIGNATURE (MANDATORY)	PHYSICIAN PHONE NUMBER	DATE (MANDATORY)
PRINT PATIENT OR PHCR NAME	PATIENT OR PHCR SIGNATURE (MANDATORY)	DATE (MANDATORY)	
PHCR RELATIONSHIP	PHCR ADDRESS	PHCR PHONE NUMBER	

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**  
 USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH

## DIRECTIONS FOR HEALTH CARE PROFESSIONALS

### COMPLETING LaPOST

- Must be completed by a physician and patient or their personal health care representative based on the patient’s medical conditions and preferences for treatment.
- **LaPOST** must be signed by a physician and the patient or PHCR to be valid. Verbal orders are acceptable from physician and verbal consent may be obtained from patient or PHCR according to facility/community policy.
- Use of the brightly colored original form is strongly encouraged. Photocopies and faxes of signed **LaPOST** are legal and valid.

### USING LaPOST

- Completing a **LaPOST** form is voluntary. Louisiana law requires that a **LaPOST** form be followed by health care providers and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient’s preferences.
- **LaPOST** does not replace the advance directive. When available, review the advance directive and **LaPOST** form to ensure consistency and update forms appropriately to resolve any conflicts.
- The personal health care representative includes persons described who may consent to surgical or medical treatment under RS 40:1159.4 and may execute the **LaPOST** form only if the patient lacks capacity.
- If the form is translated, it must be attached to a signed **LaPOST** form in ENGLISH.
- Any section of **LaPOST** 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”.
- Medically assisted nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial or would cause significant physical discomfort.
- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort focused treatment,” should be transferred to a setting able to provide comfort (e.g. pinning of a hip fracture).
- A person who chooses either “Selective treatment” or “Comfort focused treatment” should not be entered into a Level I trauma system.
- Parenteral (IV/Subcutaneous) medication to enhance comfort may be appropriate for a person who has chosen “Comfort focused treatment.”
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate “Selective treatment” or “Full treatment.”
- A person with capacity or the personal representative (if the patient lacks capacity) can revoke the **LaPOST** at any time and request alternative treatment based on the known desires of the individual or, if unknown, the individual’s best interests.
- Please see links on [www.La-POST.org](http://www.La-POST.org) for “what my cultural/religious heritage tells me about end of life care.”

**The duty of medicine is to care for patients even when they cannot be cured. Physicians and their patients must evaluate the use of technology available for their personal medical situation. Moral judgments about the use of technology to maintain life must reflect the inherent dignity of human life and the purpose of medical care.**

### REVIEWING LaPOST

This **LaPOST** should be reviewed periodically such as when the person is transferred from one care setting or care level to another, or there is a substantial change in the person’s health status. A new **LaPOST** should be completed if the patient wishes to make a substantive change to their treatment goal (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical chart.

To void the **LaPOST** form, draw line through “Physician Orders” and write “VOID” in large letters. This should be signed and dated.

## REVIEW OF THIS LaPOST FORM

REVIEW DATE AND TIME	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided and New Form Completed

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