

Southern Medical Group

**6600 Nightingale Lane
Knoxville, TN 37909
Phone (865) 632-5885
Fax (865) 632-5893**

Dear patient: _____ Date: _____

Welcome to Southern Medical Group. Enclosed in this envelope you will find the required “New Patient forms” used by SMG. The forms are being sent out before your scheduled appointment date to help your initial visit be less time consuming. THESE FORMS NEED TO BE COMPLETED AND SENT BACK TO THE OFFICE BEFORE YOUR SCHEDULED APPOINTMENT TIME IF NOT YOUR APPOINTMENT COULD BE CANCELLED.

1. The New patient packet includes:

- a. Your appointment Card**
- b. Patient Information form**
- c. The Electronic Prescription form**
- d. Authorization for Use or Disclosure of Health Information (Medical Release)**
- e. Patient Health History form(s) (if required by your Physician)**
- f. Medical Appointment Cancellation policy**
- g. Authorization for Release of Information & a Notice of privacy pamphlet**
- h. Information Regarding Advance Directives**
- i. Self address envelope to return the packet**

Note: The “Authorization for Use or Disclosure of Health Information form” you will find in the packet needs to be completed, with your previous physicians name and phone number on the line stating “records sent from”. Please make sure you sign and date the form on the required line so we can obtain your medical records before the scheduled appointment time.

If you have any questions regarding this information packet, please call the office at 865-632-5885, our office hours are Monday thru Friday between the hours of 8:00 am and 5:00 pm.

PLEASE BRING ALL INSURANCE CARDS AND DRIVERS LICENSE WITH YOU TO EACH OFFICE VISIT.

**J. Stephen Alley, M.D. Michael P. Bernard, M.D. Saeed Etezadi, M.D. Sunil John, M.D.
Douglas J. Marlow, M.D. Jeffrey A. Swilley, M.D. Robert G. Thompson, M.D. Jo Ann Bridges, PA-C**

SOUTHERN MEDICAL GROUP

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Rev. 1/13

6600 NIGHTINGALE LANE
KNOXVILLE, TN 37909
Office: (865) 632-5885
Fax: (865) 632-5893

7564 MOUNTAIN GROVE DRIVE
KNOXVILLE, TN 37920
Office: (865) 632-5885
Fax: (865) 632-5893

Date: _____

PATIENT INFORMATION										
Name (Last, First, Middle):					SSN#		Birthdate	Age	Sex	
Mailing Address					City, State, Zip					
Home Phone			Cell Phone		Email Address					
Marital Status	Student Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic		Primary Care Physician			
Referring Physician			Referring Physician Contact #		Other Medical Providers					
Race (Circle Answer): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White								Language		
Emergency Contact Name					Emergency Contact Phone #s					
					Hm:		Cell:			
Employer Name and Address							Work Phone #			
If patient is a minor, please fill out this portion										
Parent or Guardian's Name:				Parent or Guardian's Phone #s						
				Hm:		Wk:		Cell:		
RESPONSIBLE PARTY INFORMATION (if different from above)										
Name (Last, First Middle)					SSN#		Birthdate	Sex		
Address					City, State, Zip					
Home Phone		Cell Phone		Work Phone			Relationship to patient			
PRIMARY INSURANCE										
Name of Insurance Company			Name of Insured			Address of Insured (if different than address above)				
Insured's Birthdate			Insured's SSN #		Insured's Insurance ID #		Relationship to patient			
SECONDARY INSURANCE (if applicable)										
Name of Insurance Company			Name of Insured			Address of Insured (if different than address above)				
Insured's Birthdate			Insured's SSN#		Insured's Insurance ID #		Relationship to patient			
Workers Compensation										
Are you here for workers compensation YES _____ NO _____					Date:					
Accident										
Auto <input type="checkbox"/>		Work <input type="checkbox"/>		Other <input type="checkbox"/>		Date of Accident:				
Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan)					Yes _____ No _____					
Do you have a Power of Attorney?					Yes _____ No _____					
If yes to the above questions please make sure we have a copy for your medical record.										

Southern Medical Group Electronic Prescription System Information

The form listed below is necessary pharmacy information needed for our “Electronic Prescription System”. The system allows the physician to send your prescription(s) and/or refills to your pharmacy in a timelier manner.



Your Full Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

PATIENT QUESTIONNAIRE

Patient Name _____ Date ____ / ____ / ____

FAMILY HISTORY use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Diabetes									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic Depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									
SOCIAL HISTORY									
Tobacco use: Ever used tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Year started using _____ Still using tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If no: Year quit using _____ Type of tobacco used: (check all that apply) <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff/Chew Alcohol use: <input type="checkbox"/> Never <input type="checkbox"/> Daily <input type="checkbox"/> Occasional Illegal Drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe. _____									
OTHER PHYSICIANS AND PROVIDERS OF CARE									
Name & specialty/provider type					Type of care			Date of last visit	
ADVANCE DIRECTIVE									
Do you have a healthcare Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please bring a copy to your visit.									

Please complete all pages and bring with you to your visit

NAME: _____

DATE: _____

Please list any medical illness you have or have had in the past:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any and all operations you have had in the past:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

If you are a NEW PATIENT please list your medications below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

If you are a NEW PATIENT please list any drug allergies:

1. _____
2. _____
3. _____
4. _____

Please list the following:

Marital Status: _____

Children: _____

Occupation: _____

Please answer the following questions by circling yes or no:

Have you experienced a lack of interest or pleasure in doing things?

yes no

Do you feel down , depressed or hopeless?

yes no

Do you have trouble falling asleep, staying asleep, or sleeping too much?

yes no

Do you feel tired or have a lack of energy?

yes no

Do you have trouble concentrating on things such as reading or watching television?

yes no

Do you feel fidgety or restless?

yes no

Do you have thoughts of suicide or of harming yourself?

yes no

Name _____ Date: _____

PLEASE CHECK THE ITEMS BELOW WHICH APPLY TO YOU

Weight change	_____	Resipratory		Gastrointestinal	
Fatigue	_____	Frequent colds	_____	Difficulty Swallowing	_____
Weakness	_____	Sinus trouble	_____	Heartburn	_____
Sweats	_____	Postnasal drip	_____	Ulcers	_____
Chills	_____	Nosebleeds	_____	Nausea	_____
Hot flashes	_____	Snoring	_____	Vomiting	_____
Insomnia (can't sleep)	_____	Cough	_____	Stomach Pain	_____
Irritability	_____	Color	_____	Gallstones	_____
Dizziness or spinning	_____	Any blood	_____	Change in bowels	_____
Swollen Glands	_____	Sore Throats	_____	Blood in bowels	_____
Memory Loss	_____	Sputum production	_____	Vomiting blood	_____
Headaches	_____	Shortness of breath	_____	Last Colonoscopy (Yr)	_____
Passing out spells	_____	Wheezing	_____		
Seizures	_____	Pneumonia	_____	Urinary	
Concussion	_____	Chest Disease	_____	Pain	_____
				Do you wake up at	
Skin		Breasts		night to urinate?	_____
Rashes	_____	Swelling	_____	Kidney stones	_____
Itching	_____	Lumps	_____	Increased urination	_____
New moles	_____	Pain	_____	History of sexually	
Bruises	_____	Discharge	_____	transmitted disease	_____
		Date of Last Mammogram	_____	Discharge	_____
Extremities		Do you do self exams?	_____	Blood	_____
Nail Changes	_____			Incontinence	_____
Swelling	_____	Heart			
Pain	_____	Chest pain	_____	Joints	
Ulcers	_____	Shortness of breath	_____	Pain	_____
		Palpitations	_____	Weakness	_____
Eyes		Swelling of legs	_____	Gout	_____
Do you wear glasses?	_____	Murmur	_____	Tremor	_____
Date of Last Exam	_____	High cholesterol	_____	Numbness	_____
Glaucoma	_____			Back pain	_____
Pain	_____	Genitalia			
Redness	_____	Impotence	_____	Immunizations	
Operations	_____	Infertility	_____	Year of last Tetanus	_____
		Tumors	_____	Year of Pneumovax	_____
Ears		Congenital abnormalities	_____	Year of last Flu shot	_____
Change in hearing	_____	Last Pap smear	_____	History of Zostavax	_____
Discharge	_____				
Pain	_____	Neurology		Endocrine	
Ringling	_____	Strokes	_____	Diabetes	_____
		Paralysis	_____	Thyroid	_____
Skeletal				On steroids (ever)	_____
Dexa Scan (Yr)	_____				

SELF-PAY PATIENT AGREEMENT

I, _____, hereby acknowledge that at this time, my family and I are without medical health insurance coverage and, as such, I hereby agree to be personally responsible for the payment of medical services that are provided to me, my spouse and minor children. I further agree to the following:

1. I will provide my physician with the upfront payment as instructed, to be paid when I (or my spouse and minor children) present to the check in window prior to the appointment with the physician.
2. I am aware that the upfront payment may not pay the balance in full for services provided on the date of service; it is only an upfront payment.
3. Because my family and I are without medical health insurance coverage and I am personally responsible for the payment of medical services rendered to me, my spouse and minor children; I acknowledge that I may be eligible to receive a forty percent (40%) reduction in the charges for medical services rendered to me, my spouse and any minor children.
4. Following any reductions in the charges for medical services provided, I agree if I cannot pay them in full on the date services are rendered, I will pay within thirty (30) days of the date services are rendered or make alternative arrangements for the collection of such debt with the office manager or central billing office of the practice.
5. I acknowledge that failure on my part to adhere to the aforementioned may result in the dismissal of members of my family and myself from being patients of my physician.

Signature

Date

*Additional discounts may be applied if a Financial Assistance Application is completed and documentation submitted to Covenant Medical Management which indicates qualification under CMM Indigent Care Policy.

Southern Medical Group
6600 Nightingale Lane
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Notice to Patients about our Prescribing Policy

Dear Patient,

Please be advised that our office does not prescribe controlled medications, except under very limited circumstances. This would include very brief periods for severe pain, terminal diseases, etc. Medication would be written for no more than 5 days.

We do not maintain any supplies or samples of narcotics or other controlled substances in our office.

We will, in most cases, prescribe substitute, non-addicting medications which are usually sufficient. If you feel you require stronger medication, the physician will refer you to an appropriate specialist who can prescribe these medications for you.

Thank you for your understanding and cooperation.

I have reviewed the above information and understand the contents.

Patient Signature

Date

Authorization to Release Health Information

I, _____, hereby authorize _____ (the "Provider") to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____
 Address: _____ Patient's Phone: _____
 _____ Social Security No.: _____
 Phone: _____ Date of Death: _____

1. The information is to be disclosed to the following persons or organizations:

Southern Medical Group
6600 Nightingale Lane
Knoxville, TN 37909
Phone: 865-632-5885 Fax: 865-632-5893

2. Purpose. The purpose of the use or disclosure is:

- At the request of the patient
 Other: _____

If the purpose is for marketing, will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? YES NO

Will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? YES NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ (insert dates): **I understand that this information may include, but not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency/HIV.**

- Entire medical record, other than psychotherapy notes*; OR
- The following of the medical record

<ul style="list-style-type: none"> ▪ Discharge summary ▪ Lab results 	<ul style="list-style-type: none"> ▪ Progress notes ▪ Photographs, videotapes, or other images
<ul style="list-style-type: none"> ▪ History and physical exam ▪ Consultation reports ▪ X-ray reports ▪ HIV/AIDS test results and treatment ▪ Treatment plan ▪ Alcohol and drug treatment records 	<ul style="list-style-type: none"> ▪ Mental or behavioral health records ▪ Psychotherapy notes * ▪ Genetic test results ▪ Admission notes ▪ Summary of treatment

* If the authorization is for psychotherapy notes, it may not request any other part of the medical record.

• The following billing and payment information: _____

• Other information: _____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (A) one year after the date this authorization is signed or (B) on the occurrence of the following event: _____ (e.g., end of research study; final resolution of specified litigation).

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Provider will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am (*check whichever applies*):

the patient, and the identification that I have provided is true and correct.

the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 20_____.

Signature: _____

Print name: _____

Address: _____

Phone No: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Provider Use Only:

Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? Yes No

How was authority verified?: _____ Copy made? Yes No

By: _____ Title: _____ Date: _____

Southern Medical Group, P.L.L.C.
6600 Nightingale Lane
Knoxville, TN 37909
Phone: (865) 632-5885, Fax (865) 632-5893

INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make you own health care decisions.

You can also leave advance directions about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please free to ask your health provider, hospital, social worker or your attorney.

It is our policy to honor our patients' health care decisions to the full extent required or allowed by law. You are **NOT** required to give advance health care decisions in order to receive care at this facility.

Please answer the following questions:

DO YOU HAVE A LIVING WILL? Yes _____ No _____

IF YES, HAVE YOU GIVEN US A COPY? Yes _____ No _____

IF NO, WILL YOU BRING US A COPY? Yes _____ No _____

DO YOU HAVE A DURABLE POWER OF ATTORNEY? Yes _____ No _____

IF YES, HAVE YOU GIVEN US A COPY? Yes _____ No _____

IF NO, WILL YOU BRING US A COPY? Yes _____ No _____

Patient Signature

Date



Tennessee Department of Health
 Division of Health Licensure and Regulation
 Office of Health Care Facilities
 665 Mainstream Drive, Second Floor
 Nashville, TN 37243
www.tn.gov/health

ADVANCE CARE PLAN
 (Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (____) _____ Relation: _____
 Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (____) _____ Relation: _____
 Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

- I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
 I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

<input type="checkbox"/>	<input type="checkbox"/>	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

- Any organ/tissue My entire body Only the following organs/tissues: _____
-
- No organ/tissuc donation

SIGNATURE

Your signature must **either** be witnessed by two competent adults or notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____
(Patient)

DATE: _____

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Public: _____
Signature

My commission expires: _____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT
(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
(_____) _____ Area Code Home Phone Number	(_____) _____ Area Code Home Phone Number
(_____) _____ Area Code Work Phone Number	(_____) _____ Area Code Work Phone Number
(_____) _____ Area Code Mobile Phone Number	(_____) _____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.	_____ Signature of witness number 1
2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.	_____ Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

**Physician Orders for Scope Treatment (POST)
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.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.



Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name _____

First Name/Middle Initial _____

Date of Birth _____

Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.
	<input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing.
	<input type="checkbox"/> 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 <u>only</u> if comfort needs cannot be met in current location.
	<input type="checkbox"/> 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.
	<input type="checkbox"/> 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 Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions:
	<input type="checkbox"/> No Antibiotics <input type="checkbox"/> Antibiotics Other Instructions: _____

Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.	
	<input type="checkbox"/> No IV fluids (provide other measures to assure comfort)	<input type="checkbox"/> No feeding tube
	<input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> IV fluids long-term if indicated	<input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> Feeding tube long-term
	Other Instructions: _____	

Section E Must be Completed	Discussed with:	The Basis for These Orders Is: (Must be completed)
	<input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Other: _____ (Specify)	<input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other) _____

Physician's Name (Print) _____	Physician's Signature (Mandatory) _____	Date _____	Physician's Phone Number () _____
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Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated 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.

Name (Print) _____	Signature _____	Relationship (write "self" if patient) _____	
Surrogate _____	Relationship _____	Phone Number () _____	
Health Care Professional Preparing Form _____	Preparer Title _____	Phone Number () _____	Date Prepared _____

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

