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

Michigan Physician Orders for Scope of Treatment (MI-POST)

This MI-POST form is **VOID** if **Patient** Information or **Section D** are blank. Leaving blank any section of the medical orders (Sections A, B, or C), **does not void** the form and implies **full treatment** for that section.

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Gender M F
Date of Birth / /	Date Form Prepared / /
Diagnosis supporting use of MI-POST	

This form is a **Physician Order** sheet based on the medical conditions and decisions of the person identified on this form.

Paper copies, facsimiles and digital images are **valid** and should be followed as if an original copy.

This form is for adults with an advanced illness. It is not for healthy adults.

MEDICAL ORDERS

A

CARDIOPULMONARY RESUSCITATION (CPR): Person has NO pulse AND is NOT breathing.

☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B)

☐ DO NOT attempt Resuscitation/CPR (DNR/No CPR, Allow Natural Death)

B

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering through use of medication by any route, positioning, wound care and other measures. Use oxygen, manual suction treatment of airway obstruction and non-invasive respiratory assistance as needed for comfort. Food and water provided by mouth as tolerated.

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to care described in comfort-focused treatment**,** use IV fluid therapies, cardiac monitoring including cardioversion, and non-invasive airway support (CPAP, BiPAP) as indicated. DO NOT use advanced invasive airway interventions or mechanical ventilation.
May involve transportation to the hospital. Generally avoid intensive care.

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to care described in selective treatment, use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated.
Likely to involve transportation to the hospital. May include intensive care.

C

ADDITIONAL ORDERS: Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, nutrition, long-term life-support, medications, and blood products.

_____

_____

_____

_____

_____

D

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER (NP) OR PHYSICIAN ASSISTANT (PA)

My signature below indicates that these orders are medically appropriate given the patient's current medical condition and reflect to the best of my knowledge the patient's goals for care.

Signature	Date
Name (print)	Phone #

COMPLETE BELOW IF ORDERS ARE ISSUED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

Name of collaborating Physician (print)	Phone #

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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Patient Last Name:	**Patient First Name:**

E

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

My signature indicates I have discussed, understand and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that If I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

☐ Patient ☐ Patient Advocate/Durable Power of Attorney for Healthcare (DPOAH) ☐ Court-appointed Guardian

Name	Signature	Date

INFORMATION OF LEGALLY AUTHORIZED REPRESENTATIVE
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAH or Court-appointed Guardian

Address	Phone #	Alternate Phone #

F

INDIVIDUAL ASSISTING WITH COMPLETION OF MI-POST FORM

Preparer's Name (print)	Title	Date
Preparer's Signature	Organization	Phone #

G

TO REAFFIRM OR REVOKE THIS FORM

This MI-POST form can be reaffirmed or revoked at any time. If any of the following has occurred, the form must be revoked or reaffirmed by the patient or patient representative **and** the Attending Health Care Provider within the time frame indicated from the time the event occurred, or the form will be considered VOID.

- **One year** from the date since the form was last signed or reaffirmed
- **30 days** from a change in the patient's attending health care provider
- **1 week** from a change in the patient's place of care, level of care, or care setting; or any unexpected change in the patient's medical condition

Reaffirming this MI-POST form indicates there are no changes and requires signatures with dating of reaffirmation below. If treatment changes are desired, revocation of this MI-POST form is required, and a new MI-POST form should be completed. Write "revoked" over the signatures of the patient or patient representative; **and** the signature(s) of the Attending Healthcare Provider, in Sections D and G, if used, on this MI-POST form

- Write "VOID" diagonally on both sides in large letters and dark ink
- Take reasonable action to notify attending health professional, patient, patient representative, and care setting.

If a section was previously blank (Sections A, B or C) and is later completed, follow the procedures for reaffirming.
If a new form is not completed, full treatment and resuscitation will be provided.

Reaffirmation #1		Reaffirmation Date
Healthcare Provider Name/Collaborative Physician if applicable	Patient/Representative Name	
Healthcare Provider Signature	Patient/Representative Signature	
Reaffirmation #2		Reaffirmation Date
Healthcare Provider Name/Collaborative Physician if applicable	Patient/Representative Name	
Healthcare Provider Signature	Patient/Representative Signature	
Reaffirmation #3		Reaffirmation Date
Healthcare Provider Name/Collaborative Physician if applicable	Patient/Representative Name	
Healthcare Provider Signature	Patient/Representative Signature	
Reaffirmation #4		Reaffirmation Date
Healthcare Provider Name/Collaborative Physician if applicable	Patient/Representative Name	
Healthcare Provider Signature	Patient/Representative Signature	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED