JOHNSON MEMORIAL Hospital

1125 West Jefferson Street
Franklin, IN 46131
(317) 736-3300
www.johnsonmemorial.org

September , 2015

Patient Handbook

A list of hospital, community, and certified persons proficient in foreign languages and American Sign Language is maintained. If you or your family requires the assistance of an interpreter, ask your nurse. Every effort will be made to find someone to assist you.

Una lista de las personas hospital, comunidad y certificadas hábil en los idiomas extrajeros y el Idioma de Señal de americano se mantiene. Si usted o su familia requieren la ayuda de un intérprete, pregúntele a la enfermera. Cada esfuerzo se hará encontrar a alguien para ayudarlo.

Dear Valued Customer,

Welcome! Thank you for choosing Johnson Memorial Hospital. We are committed to providing you with the highest quality healthcare and we pledge every effort to ensure that your stay is as pleasant as possible. Your satisfaction is our ultimate goal.

Your comfort and satisfaction are important to us and this Patient Handbook has been designed to provide answers to many of the questions you may have. Please take a few minutes to read the information provided. Should you have additional questions, please feel free to ask a staff member. Our staff will be happy to assist you or, if necessary, refer you to the appropriate person to provide answers to your questions.

We are proud of our hospital staff, medical staff, and facility. Our mission is to *"provide quality healthcare services for our community"* and we are constantly striving to expand and improve our services to achieve that goal. We truly want to be *your* provider of choice and we appreciate the confidence you have placed in us by choosing Johnson Memorial Hospital for your health care needs.

Sincerely,

Larry Heydon
President/CEO

Welcome to Johnson Memorial Hospital

Your Rights and Responsibilities as a Patient

Being a patient at Johnson Memorial Hospital entitles you to certain rights as well as obligating you to several responsibilities.

YOUR RIGHTS AS A PATIENT:

You are entitled to these rights regardless of sex, race, cultural, economic, educational or religious background, sexual orientation, age, handicap or the source of payment for your health care. All your rights as a health care consumer also apply to the person who may have legal responsibility to make decisions regarding your health care. The hospital and the medical staff have adopted the following statement of Patient Rights. As a patient at Johnson Memorial Hospital, you have the right to:

a. Participate in the development and implementation of his or her plan of care;
b. His or her representative (as allowed under state or federal law) has the right to make informed decisions regarding his or her care. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate;
c. Exercise advance directive regarding decisions at the end of life in accordance with Federal and State Patient Self-Determination Act(s);
d. Have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital;
e. Personal Privacy;
f. Receive care in a safe setting;
g. Be free from all forms of abuse or harassment;
h. Confidentiality of your clinical records maintained by the facility;
i. Access to information contained in your clinical records within a reasonable time frame;
j. Free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff;
k. Be fully informed of, and to consent or refuse to participate in any unusual, experimental or research project without compromising access to services;
l. Know the professional status of any person providing your care/services;
m. Know the reasons for any proposed change in the Professional Staff responsible for your care;
n. Know the reasons for your transfer either within or outside the facility;
o. The relationship(s) of the facility to other persons or organizations participating in the provision of your care;
p. Access to the cost, itemized when possible, of services rendered within a reasonable period of time;
q. Be informed of the source of the facility's reimbursement for your services and of any limitations which may be placed upon your care;
r. Have pain treated as effectively as possible;
s. Visitation rights based on the patient's, or designated support person's consent to receive whom he or she designates and will be informed of any clinically necessary or reasonable restrictions or limitations on such rights;

t. The patient's family has the right of informed consent for donation of organs and tissues.

YOUR RESPONSIBILIITES AS A PATIENT:

Along with your rights as a patient come responsibilities to ensure the high quality health care that you deserve. As a patient at Johnson Memorial Hospital, you have the responsibility to:

- Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses and hospitalization, medication and other matters relating to your health;
- Follow the treatment plan as recommended by your physicians;
- Follow hospital rules and regulations affecting patient care and conduct;
- Be considerate of the rights of other patients and hospital personnel and for your behavior in the control of noise, smoking and the number of visitors;
- Assure that the financial obligations of your health care are fulfilled;
- Show respect for your personal property as well as the property of others and that of the hospital.
- Make it known whether you clearly comprehend your course of medical treatment and what is expected of you. You are encouraged to ask questions necessary for a clear understanding of any course of action and what to expect. If the nursing staff is unable to answer questions to your satisfaction, your personal physician will be notified to explain any questions that you may have.
- The patient is responsible for keeping appointments and for notifying the hospital or physician when unable to do so.
- The patient is responsible for his/her actions should treatment be refused or physician's orders not followed.
- As we cannot accept responsibility for valuables left in your room, we strongly encourage you to give extra money, medications, credit cards, wallets, jewelry, etc. to a family member or close friend to take home. Or, ask your nurse to put your valuables in the hospital safe. An itemized receipt and claim ticket will be provided to you. Please be sure to take all of your personal items home with you at dismissal. Do not leave items such as dentures, hearing aids and eyeglasses on the food tray or bed. This could result in loss for which Johnson Memorial Hospital is not responsible for these losses.

VISITATION RIGHTS

Visitation is an important part of healing and the hospital permits visitation when it is in the best interest of the patient.

- Visitation rights based on the patient's, or designated support person's consent to receive whom he or she designates and will be informed of any clinically necessary or reasonable restrictions or limitations on such rights;
- The hospital does not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.
- The hospital ensures that all visitors designated by the patient will have the same visitation privileges that are no more restrictive than those of the immediate family.
- The hospital requests that visitors respect the patient's need for rest and privacy.
- In special circumstances (during medical procedures, surgery, or crisis situations) visitors may be asked to leave the room)
- It is requested that visitors who are ill refrain from coming to the hospital for the protection of the patient.
- Any visitor who is disruptive may be asked to leave or be escorted from the building.
- No visitors are allowed if the patient is under law enforcement surveillance.

Health Care Dilemmas

Johnson Memorial Hospital and the medical staff support your right to actively participate in decisions regarding your health care program, including decisions regarding the right to refuse life-sustaining treatment. In compliance with federal law, this handbook serves as your basic "Notice of Patient Rights." For additional information you may contact your caregiver or our Patient Advocate at (317) 346-3929.

Feelings of anxiety and uncertainty often affect both you and your family when you are hospitalized. Sometimes you or your family members may have a dilemma related to your plan of care. If you have a dilemma or conflict with your planned course of treatment, you may request a meeting with the hospital's Ethics Committee.

The Ethics Committee provides a consulting service to patients, physicians and hospital personnel when ethical considerations or personal dilemmas arise, as to the extent of treatment of irreversible or terminal conditions. Usually the Ethics Committee is convened when there is a conflict between any of the involved parties relating to levels of treatment that are planned for you. Examples of ethical concerns are: A patient being placed on a ventilator, or receiving other such treatment, against their expressed desires or loved ones cannot agree on the care being provided.

If you or your family members would like to meet with the Ethics Committee, or if you would like the committee to review your care in terms of planned treatment for your irreversible or terminal condition, inform your nurse. Your nurse will contact the appropriate parties and a meeting with a member of the Ethics Committee will be arranged. The Ethics Committee offers recommendations but does not make decisions about your care.

Concerns during your hospitalization – Contacting the Patient Advocate

At Johnson Memorial Hospital your satisfaction with all care provided is important to us. Should you or your family members experience concerns about the care you are receiving, you may contact the Patient Advocate and discuss any issues that did not meet your expectations. You may call the Patient Advocate during your hospitalization between 8:00 a.m. and 4:00 p.m., Monday through Friday, by dialing extension 3929, or after you are discharged, by dialing (317) 346-3929. We encourage you to voice your opinion regarding the care you have received and we welcome your comments.

The Grievance process

The Grievance process provides a way for patients to voice a complaint that cannot be resolved or when significant quality of care or early discharge issues arise. You may call the Patient Advocate during your hospitalization between 8:00 a.m. and 4:00 p.m., Monday through Friday, by dialing extension 3929, or after you are discharged, by dialing (317) 346-3929. You may also communicate your concerns in writing to: Patient Advocate Coordinator, Johnson Memorial Hospital 1125 W. Jefferson Street, P.O. Box 549, Franklin, IN 46131. Every attempt will be made to respond to patient complaints and/or grievances promptly or within seven (7) working days of receipt.

The Patient retains the right at all times to notify any appropriate state or federal regulatory agencies governing healthcare organizations. Johnson Memorial Hospital supports the patient's right to voice concerns and will provide assistance in contacting any appropriate regulatory agencies requested, including:

Indiana State Department of Health

2 North Meridian St.
Indianapolis, IN 46204
(317) 233-1325

Peer Review Organization

KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-855-408-8557

SPEAK UP

Everyone has a role in making health care safe; physicians, health care executives, nurses and technicians. Health care organizations across the country are working to make health care safety a priority. You, as the patient, can also play a vital role in making your care safe by becoming an active, involved and informed member of your health care team. An Institute of Medicine (IOM) report has identified the occurrence of medical errors as a serious problem in the health care system. The IOM recommends, among other things, that a concerted effort be made to improve the public's awareness of the problem.

The "Speak Up" program, sponsored by the Joint Commission on Accreditation of Healthcare Organizations, urges patients to get involved in their care. Such efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services. This initiative provides simple advice on how you, as the patient, can make your care a positive experience. After all, research shows that patients who take part in decisions about their health care are more likely to have better outcomes.

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

- Your health is too important to worry about being embarrassed if you don't understand something that your doctor, nurse or other health care professional tells you.
- Don't be afraid to ask about safety. If you're having surgery, for example, ask the doctor to mark the area that is to be operated upon, so that there's no confusion in the operating room.
- Don't be afraid to tell the nurse or the doctor if you think you are about to receive the wrong medication.
- Don't hesitate to tell the health care professional if you think he or she has confused you with another patient.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

- Tell your nurse or doctor if something doesn't seem quite right.
- Expect health care workers to introduce themselves when they enter your room and look for their identification badges. A new mother, for example, should know the person to whom she is handing her baby. If you are unsure, ask.
- Notice whether your caregivers have washed their hands. Hand washing is the most important way to prevent the spread of infections. Don't be afraid to gently remind a doctor or nurse to do this.
- Know what time of day you normally receive a medication. If it doesn't happen, bring this to the attention of your nurse or doctor.
- Make sure your nurse or doctor confirms your identity, that is, checks your wristband or asks your name, before he or she administers any medication or treatment.

Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.

- Ask your doctor about the specialized training and experience that qualifies him or her to treat your illness (and be sure to ask the same questions of those physicians to whom he or she refers you).
- Gather information about your condition. Good sources include your doctor, your library, and respected websites and support groups.
- Write down important facts your doctor tells you, so that you can look for additional information later. And ask your doctor if he or she has any written information you can keep.
- Thoroughly read all medical forms and make sure you understand them before you sign anything. If you don't understand, ask your doctor or nurse to explain them.
- Make sure you are familiar with the operation of any equipment that is being used in your care. If you will be using oxygen at home, do not smoke or allow anyone to smoke near you while oxygen is in use.

Ask a trusted family member or friend to be your advocate.

- Your advocate can ask questions that you may not think of while you are under stress.
- Ask this person to stay with you, even overnight, when you are hospitalized. You will be able to rest more comfortably and your advocate can help to make sure you get the right medications and treatments.
- Your advocate can also help remember answers to questions you have asked, and speak up for you if you cannot.
- Make sure this person understands your preferences for care and your wishes concerning resuscitation and life support.
- Review consents for treatment with your advocate before you sign them and make sure you both understand exactly what you are agreeing to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse and whom to call for help.

Know what medications you take and why you take them. Medication errors are the most common health care mistakes.

- Ask about the purpose of the medication and ask for written information about it, including its brand and generic names. Also inquire about the side effects of the medication.
- If you do not recognize a medication, verify that it is for you. Ask about oral medications before swallowing, and read the contents of bags of intravenous (IV) fluids. If you're not well enough to do this, ask your advocate to do this.
- If you are given an IV, ask the nurse how long it should take for the liquid to "run out." Tell the nurse if it doesn't seem to be dripping properly (that it is too fast or too slow).
- Whenever you are going to receive a new medication, tell your doctors and nurses about allergies you have, or negative reactions you have had to medications in the past.
- If you are taking multiple medications, ask your doctor or pharmacist if it is safe to take those medications together. This holds true for vitamins, herbal supplements and over-the-counter drugs, too.

- Make sure you can read the handwriting on any prescriptions written by your doctor. If you can't read it, the pharmacist may not be able to either.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established, state-of the-art quality and safety standards, such as that provided by JCAHO.

- Ask about the health care organization's experience in treating your type of illness. How frequently do they perform the procedure you need and what specialized care do they provide in helping patients get well?
- If you have more than one hospital or other facility to choose from, ask your doctor which one offers the best care for your condition.
- Before you leave the hospital or other facility, ask about follow-up care and make sure that you understand all of the instructions.
- Go to Quality Check at www.jcaho.org to find out whether your hospital or other health care organization is accredited.

  The Healthcare Facilities Accreditation Program (HFAP) accredits Johnson Memorial Hospital. You can view hospitals that are accredited by HFAP at *www.aoa-net.org/Accreditation/HFAP/hospitals.htm*.

Participate in all decisions about your treatment. You are the center of the health care team.

- You and your doctor should agree on exactly what will be done during each step of your care.
- Know who will be taking care of you, how long the treatment will last, and how you should feel.
- Understand that more tests or medications may not always be better. Ask your doctor what a new test or medication is likely to achieve.
- Keep copies of your medical records from previous hospitalizations and share them with your health care team. This will give them a more complete picture of your health history.
- Don't be afraid to seek a second opinion. If you are unsure about the nature of your illness and the best treatment, consult with one or two additional specialists. The more information you have about the options available to you, the more confident you will be in the decisions made.
- Ask to speak with others who have undergone the procedure you are considering. These individuals can help you prepare for the days and weeks ahead. They also can tell you what to expect and what worked best for them as they recovered.

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HEALTH AND SAFETY

Smoking Policy

Johnson Memorial Hospital is a smoke free campus. As a health care institution, Johnson Memorial Hospital recognizes the hazards of smoking and enforces a "no smoking policy" throughout the institution and on the grounds.

Quitting Smoking

Do you smoke tobacco products? Being in the hospital is a great time to quit. Take advantage of our smoke free environment. Because you cannot smoke while you are here, you have already taken the first steps to a smoke free lifestyle.

Smoking has been directly linked to lung disease, heart disease, peripheral artery disease, stroke, bladder cancer, cervical cancer, and high blood pressure. It reduces blood flow, so if you are here for surgery you will heal slower. It causes wrinkles. If you are pregnant, it can cause miscarriage, still birth, and birth defects.

Secondhand smoke can be harmful to those around you. Children exposed to secondhand smoke have more ear infections, tonsillitis, asthma, and sudden Infant Death Syndrome (SIDS). Some adults have even developed emphysema or asthma from exposure to second hand smoke.

The staff at Johnson Memorial can help you in your efforts to quit. Your nurses may have asked you about smoking already. They will be happy to send someone in to talk to you about making a plan to quit.

We also would like to encourage you to talk to your physician about quitting while you are here. Nicotine is an extremely addictive substance. Do you need medication to help you during the first stages of quitting? There are a wide variety of medications that your doctor can prescribe for you.

At Johnson Memorial, our mission is to provide quality healthcare services for our community. Let us help improve your health or that of any smoker you know. Talk to your doctor or nurse, or ask to speak to a Respiratory Therapist. We are happy to help you quit.

Medication

Please give your nurse a list of any medications you are taking, including dosage and times. Your nurse will review these with your physician who will make a decision on which medications you should continue to take during your hospitalization. Your nurse will bring your medication to you as ordered by your physician. All medications you may have brought with you, including aspirin, should be returned home as they can interfere or interact with tests or medicines ordered for your treatment.

For your safety and protection, in acute care, only medicines approved by your physician and supplied by our Pharmacy will be given to you during your stay. Your nurse will ask you questions concerning your past responses to medications and any allergies you may have. You may be asked to wear an allergy bracelet, which alerts all caregivers to your allergies.

Other Safety Concerns

We request that you push your nurse call button at any time to request help getting out of bed, in and out of a wheelchair, or to the bathroom. If a bedpan or urinal is out of reach, please don't attempt to reach it. The most frequent type of patient accident involves patients falling and the leading cause of these falls is the patient's unwillingness to ask for help. Please allow us to assist you during your hospital stay.

In the unlikely event of a fire or other emergency, please stay in your room and wait for instructions from hospital staff. If the fire is in your room, notify the nursing station immediately.

All personal electrical equipment such as radios and electric shavers must be examined by the Bio-Medical Department for general safety before being used. You will be asked to send potentially unsafe items home. There may be other items you bring to the hospital that we may ask you to send home because of hospital safety policies. We appreciate your cooperation.

Privacy

At the time of your registration you were asked if you wanted to be listed in the hospital directory. If you are listed in the hospital directory we will be able to tell your friends and family your room and telephone number. If you elected to not be listed in the directory or were unable to make the election and change your mind, inform your Nurse that you want to change your election and the change will be made.

IF YOU NEED SURGERY

If during your hospital stay it is determined that you need surgery your physician may order a sedative to be given to you during the night before your surgery. The Nursing Staff will instruct you if you are able to eat or during after midnight before your surgery. On the Day of Surgery it may be necessary for your nurse to prepare the area of your body where the surgery will take place. If ordered by your anesthetist, you may receive medications about one hour before your surgery. After your surgery, you will be taken to the Post Anesthesia Recovery Room where specially trained nurses will monitor your blood pressure, pulse, breathing and intensity of pain every fifteen minutes until you are ready to return to your room. You can expect to continue having frequent checks on your pulse, breathing, blood pressure, and pain as well as observation of your surgical site dressings and maintenance of IV solutions. You will be allowed liquids as ordered by your surgeon. Be sure to tell your nurse if you are uncomfortable in any way.

Outpatient Surgery

Outpatient surgery cases will be returned to the Outpatient Surgery Department. Frequent checks on your pulse, blood pressure and breathing will also be performed until your physician determines you are ready to be discharged. In the Outpatient Surgery setting, most patients are allowed a small meal when they feel hungry and state they are ready to eat. Please inform your nurse if you become nauseated or are having discomfort. You may be discharged from the Outpatient Surgery Department in the care of a responsible adult. If you have had an ambulatory surgery procedure, your visitors may accompany you to the Outpatient Surgery Department and wait with you until it is time to prepare you for your procedure. During your surgery visitors may wait in the Surgery Waiting Room near the Surgery Department.

Visitors during your surgery

Even the most minor of surgical procedures may produce feelings of anxiety. Johnson Memorial Hospital encourages you to have someone, with whom you are close, visit you before and after your surgery. Having a friend or family member present can relax you and give you a sense of comfort and security. While you are in the Surgical Suite, your family and friends may wait in the Surgery Waiting Room, near the Surgical Department. Your visitors will be contacted in the Surgery Waiting Room and informed about your condition and when you will be transferred back to your room, after your recovery period has concluded.

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Indiana State Department of Health

2 North Meridian Street
Indianapolis, Indiana 46204
March 1999
Revised May 2004
Revised July 1, 2013

ADVANCE DIRECTIVES
YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

"Advance directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- ♦Talking directly to your physician and family
- ♦ Organ and tissue donation
- ♦ Health care representative
- ♦ Living Will Declaration or Life-Prolonging Procedures Declaration
- ♦ Psychiatric advance directives
- ♦ Out of Hospital Do Not Resuscitate Declaration and Order
- ♦ Physician Orders for Scope of Treatment (POST)
- ♦ Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16.1. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16 -36 -1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life - prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are not in a hospital when an emergency occurs, the emergency medical personnel or the hospital where you are sent likely would not have a physician's order to implement your directives. For situations outside of a hospital, the *Out of Hospital Do Not Resuscitate Declaration and Order* is used to state your wishes. The *Out of Hospital Do Not Resuscitate Declaration and Order* is found at Indiana Code § 16-36-5.

The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene your desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

A "Physician Orders for Scope of Treatment" (also referred to as a POST form) is a direct physician order for a person with at least one of the following:

1. An advanced chronic progressive illness.
2. An advanced chronic progressive frailty.
3. A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty there can be no recovery and death will occur from the condition within a short period without the provision of life prolonging procedures.
4. A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

In consultation with you or your legal representative, your physician will write orders that reflect your wishes with regards to cardiopulmonary resuscitation (CPR), medical interventions (comfort measures, limited additional interventions, or full treatment), antibiotics and artificially administered nutrition.

You additionally have the option on the POST form to designate a "Health Care Representative" [see the section "Health Care Representative" above for additional information]. Note that if you have previously designated a health care representative and you name a different person on your POST form, the person designated on the POST form replaces (revokes) the person named in the previous health care representative advance directive. The Indiana POST form is available on the Indiana State Department of Health website at www.in.gov/isdh/25880.htm.

The POST form must be signed and dated by you (or your legal representative) and your physician to be valid. The original form is your personal property and you should keep it. Paper, facsimile (fax), or electronic copies of a valid POST form are as valid as the original. Your physician is required to keep a copy of your POST form in your medical record or; if the POST form is executed in a health facility, the facility must maintain a copy of the form in the medical record. The POST form may be used in any health care setting. The Physician Orders for Scope of Treatment statute is found at Indiana Code § 16-36-6.

Executed POST forms may be revoked at any time by any of the following:

1. A signed and dated writing by you or your legal representative.
2. Physical cancellation of destruction of the POST form by you or your legal representative.
3. Another individual at the direction of you or your legal representative.
4. An oral expression by you or your legal representative of intent to revoke the POST form.

The revocation is effective upon communication of the revocation to a health care provider.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one
state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

Several of the forms are specified by statute. Those forms may be found on the Indiana State Department of Health (ISDH) Advance Directives Resource Center at www.in.gov/isdh/25880.htm. The following forms are available on that web site:

- ♦ Living Will Declaration
- ♦ Life-Prolonging Procedures Declaration
- ♦ Out of Hospital Do Not Resuscitate Declaration and Order
- ♦ Physician Orders for Scope of Treatment (POST)

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

ADDITIONAL INFORMATION

For additional information on advance directives, visit the Indiana State Department of Health Advanced Directives Resource Center located at www.in.gov/isdh/25880.htm. The site includes links to state forms, this brochure, links to Indiana statutes, and links to other web sites.

The ISDH Web site contains a wealth of information about public health. Visit the ISDH Home Page at www.in.gov/isdh.

SUMMARY OF ADVANCE DIRECTIVES

♦ You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.

♦If you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.

♦No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.

♦This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

Conclusion

It is difficult for people to make good decisions when they are under pressure or emotional stress in areas where there are no clear-cut answers such as the use of life-support treatment and organ donation. These issues require a great deal of discussion and careful thought. This information is being provided for your review to encourage you to discuss it with your doctor and others, and come to a decision that is right for you or someone you love.

NOTES:_____

_____

_____

_____

_____

_____

Telephone Service

A telephone is available in each patient room. Friends and family may dial your private phone number directly.

To make local calls at no charge:

1. Press "9"
2. Wait for a dial tone
3. Press the number you wish to call.

To make long-distance calls:

1. Press " 9 " and the toll free number on your phone card.
2. To make a collect call, dial " 0 ", operator and they will connect you with a direct collect number. Long-Distance telephone cards are available in the hospital gift shop located on the 1st floor. **Long-distance calls cannot be included on your hospital bill.**

TTY Services

TTY services are available through the Emergency Department. This equipment makes it possible for speech and hearing impaired individuals with corresponding equipment to communicate their medical emergencies to our emergency personnel.

Cellular Telephones

Cellular telephones use is not restricted. It is expected that consideration will be given to others when you are making or receiving calls that may be disruptive in patient care or visitation areas.

Television Service

There is a television with remote control assigned to each patient bed. For the rest and welfare of all our patients the television must be kept at a low volume.

Language interpreters

A list of hospital, community and certified persons proficient in foreign languages and American Sign Language is maintained. If you or your family requires the assistance of an interpreter, ask your nurse. Every effort will be made to find someone to assist you.

Spiritual Care

The Johnson Memorial Hospital Chaplaincy Program is available for care, counseling, referral, and follow-up of patients, residents, visitors, associates and their families. Your nurse will contact the Chaplain Service at your request. A chapel is available 24 hours a day and is located on the 1st floor next to the gift shop.

Students in Clinical Training

Johnson Memorial Hospital serves as the clinical facility for several groups of students, such as, medical, nursing, paramedic, radiology, and nutrition services students. Working at the hospital allows the students to gain valuable experience that will prepare them for their professional roles. If you agree to have students participate in your care, your doctor and/or hospital staff members, as well as an instructor from their school will closely supervise them. Students do not function independently. Working with a student can be a pleasant experience for both you and the student. We hope students will contribute to the high quality of care you will receive during your stay at Johnson Memorial Hospital.

DISCHARGE

Our discharge planners can provide you with information about home health care, medical equipment, skilled nursing facilities, transportation, and Meals-on-Wheels and other community resources. Assistance with questions regarding Medicare, Medicaid, Social Security, State Disability and Worker's Compensation can also be provided.

The Case Management Department has information on many community resources, which are available to assist you following discharge from the hospital. Please call the Case Management Department at (317) 736-2687 if you would like information about any community resources that you may find helpful.

Going Home

Your physician will decide when you are ready to be discharged and will advise the nursing personnel. When you are prepared to be discharged please pick up any valuables that you may have in the hospital safe. Your nurse will assist you in gathering your belongings and check to make sure you return home with all items that you had upon arrival to the hospital. Wheelchair transportation is available to any department within the hospital and to your car.

A responsible adult needs to be available to provide transportation to your home. If this is not possible the hospital will make every effort to help you coordinate your transportation. Should you experience difficulties with transportation, please notify your nurse and she/he will assist you.

At Home

If there has been a visiting nurse or home health professional arranged to visit you in your home you will be informed of this by the hospital discharge planner. If home care services are not provided as planned, please call (317) 736-2687 and let the discharge planner know, so that further arrangements can be made. Should you experience any condition that concerns or causes you alarm, contact your physician immediately. Our Emergency Department is open 24-hours a day, and should you be unable to contact your physician, or if your condition is such that you feel you should be seen immediately, arrange for a responsible adult to bring you to the Emergency Department.

Financial Matters

The patient or in the case of a minor child, the biological parents or legal guardian is responsible for the payment of the hospital bill.

Physician Bills

In addition to your hospital bill, you may receive separate bills from each physician involved in your care while in the hospital. Physicians render independent professional services which are separate from the hospital bill. Depending on your individual treatment these may include your Personal Physician, Consulting Physician, Radiologist, Pathologist, Anesthesiologist, and Emergency Department Physicians who may have seen you during your stay, or who interpreted results from various tests performed. Just like your attending physician, they are independent practitioners with privileges to practice medicine here at Johnson Memorial. As such, their fees are not included in the hospital bill. If you have any questions regarding these bills you should call their billing offices directly at the telephone numbers listed on the statement sent to you.

Your Hospital Bill

If you provided insurance as a method of payment for your hospital bill, a call will be made to verify your benefits and eligibility. If your insurance validates coverage, a bill will sent to your insurance for services rendered but you are ultimately responsible for those charges. Your insurance policy is a contract between you and your insurance company. You should know what is covered, not covered, and what requirements are included in your health insurance benefits. Your physician may recommend treatment and other procedures not covered by your health plan because he or she is prescribing based on your health needs, not your insurance benefit coverage. Always contact your insurance company if you are unsure of whether or not something is a covered benefit. Your insurance plan will be given an appropriate time to acknowledge our claim and pay the bill in accordance to your benefits. You will be billed for any deductible, co-pays and coinsurance deemed your liability by your insurance plan. If your insurance does not pay the bill you will receive a bill indicating their lack of payment. If you believe that your insurance should have paid, you will need to contact your insurance company, employer or other parties designated by your employer to resolve your dispute.

Financial Assistance:

If you believe you may require financial assistance to pay for your care, you should contact the Patient Accounts Department at extension 7880 while you are in the hospital or (317) 738-7880 as soon as possible. You will not be denied medical services solely because of inability to pay for those services.

Payment Plans:

If you are unable to pay for your services with 30 days of the receipt of your first statement, Johnson Memorial Hospital offers a variety of payment plan options. For short term payment plans, no interest is charged. For longer payment plans, an interest is applied to the unpaid balance. You may arrange a payment plan before you leave the hospital or in elective services, prior to the service being rendered.

Patient Responsibility:

An expected insurance payment to JMH does not replace the patient's obligation to pay any outstanding balance. JMH reserves the right to expect payment directly from the patient or the responsible party in certain situations or if insurance payment is particularly slow. JMH also reserves the right to request pre-payment for scheduled services. The pre-payment may be a portion of the expected cost of services or the amount of deductible or co-payment or coinsurance deemed the patient's liability by their individual insurance plan.

NOTES:

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I,

_____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short period of time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration);

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my **attorney in fact** with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full impact of this declaration.

_____ _____

Signature Street Address

_____ _____

City, County and State of Residence Social Security Number

_____

Date of Birth

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

Witness:	_____	Witness:	_____
Date:	_____	Date:	_____
Address:	_____	Address:	_____
Telephone Number:	_____	Telephone Number:	_____

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I voluntarily appoint the following person as my health care representative. My representative is authorized to act for me in all matters of health care in accordance with IC 16-36-1 and IC 30-5 et. seq., except as otherwise specified below**.**

_____	_____
Appointed Health Care Representative	Address
_____	_____
Telephone Number	City
_____	_____
Social Security Number	State & Zip Code

I authorize my health care representative to make decisions in my best interest concerning consent to treatment and the withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician(s) and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others; to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions:

This appointment becomes effective and remains effective if I am incapable of consenting to my health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, year of _____

_____	_____
Signature	Street Address
_____	_____
Print Full Legal Name	City, County & State of Residence
_____	_____
Date of Birth	Social Security Number

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above-named individual making the appointment, I witnessed the signing of this document by the Appointee on the date noted above**.**

_____	_____
Witness Signature	Street Address
_____	_____
Witness (Please Print Full Legal Name)	City, County & State of Residence

Telephone Number _____

LIFE-PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____, year of _____.

I, _____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal rights to request medical or surgical treatment and accepts the consequences of the request.

I understand the full import of this declaration.

_____ _____

Signature Social Security Number

_____ _____

Date of Birth City, County and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years old.

Witness: _____ Date:_____

_____ _____

Street Address/City Telephone Number

Witness: _____ Date: _____

_____ _____

Street Address/City Telephone Number

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (6-13)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: Follow these orders first. Contact treating physician, advanced practice nurse, or physician assistant for further orders if indicated. Emergency Medical Services (EMS) should contact Medical Control per protocol. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. Original form is personal property of the patient.

Patient Last Name	Patient First Name	Middle Initial

Birth date *(mm/dd/yyyy)*	Medical Record Number	Date prepared *(mm/dd/yyyy)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse AND is not breathing.*

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation (DNR)

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

B *Check One*

MEDICAL INTERVENTIONS: *If patient has pulse AND is breathing OR has pulse and is NOT breathing.*

☐ *Comfort Measures (Allow Natural Death)*: Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ *Limited Additional Interventions*: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ *Full Intervention*: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

E

DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:

☐ Patient (patient has capacity) ☐ Health Care Representative

☐ Legal Guardian / Parent of Minor ☐ Health Care Power of Attorney

SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE

My signature below indicates that my physician discussed with me the above orders and the selected orders correctly represent my wishes.
If signature is other than patient's, add contact information for representative on reverse side.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F

SIGNATURE OF PHYSICIAN

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

Print Signing Physician Name ***(required by statute)***	Physician Office Telephone Number ***(required by statute)*** ( ) _____ – _____	License Number ***(required by statute)***

Physician Signature ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*	Office Use Only

Information for Patient about Physician Orders for Scope of Treatment (POST)

The Indiana Physician Orders for Scope of Treatment (POST) form is always voluntary. POST is based on your goals of care and records your wishes for medical treatment. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. No form can address all the medical treatment decisions that may need to be made. An Advance Directive, including appointing someone to speak on your behalf if you cannot speak for yourself, is recommended. You can identify a health care representative in the box below if you have not already done so. HIPAA permits disclosure to health care professionals as necessary for treatment.

Designation of Health Care Representative *(Optional)*

Name of Health Care Representative	Telephone Number (____)-_____-_____
Relationship to Patient	Address *(number and street, city, state, and ZIP code)*

I hereby appoint the above named person as my representative to act in my behalf on all matters concerning my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation above supersedes (replaces) any prior named Health Care Representative(s).

Patient Signature	Date *(mm/dd/yyyy)*	Witness (adult other than designated Health Care Representative)

Contact Information for Sections E and F

Relationship of Representative identified in Section E if patient has no capacity ***(required by statute)***	Address	Telephone Number
Healthcare Professional Preparing Form if other than the person named in Section F	Preparer Title	Telephone Number

Directions for Health Care Professionals

Completing Physician Orders for Scope of Treatment (POST)

- POST orders should reflect current treatment preferences of the patient.
- If the patient lacks capacity, the form may be completed by legally appointed guardian, healthcare representative, healthcare power of attorney, or parent of minor. The authority of the named Health Care Representative is bound by Indiana statutes.
- Verbal / telephone orders are acceptable with follow-up signature by physician in accordance with facility/community policy and state law.
- The POST form is the personal property of the patient. Use of original form is encouraged, however photocopies, electronic copies and faxes are also legal and valid.

Using Physician Orders for Scope of Treatment (POST)

- Persons who are in need of emergency medical services because of a sudden accident or injury outside the scope of the person's illness should receive treatment to manage their medical needs.
- Any section of these POST orders not completed implies full treatment for that section.
- Oral fluids and oral nutrition must always be offered if medically feasible.
- Comfort care is never optional. When comfort cannot be achieved in the current setting, the person, including someone designating "Comfort Measures," should be transferred to a setting able to provide comfort (e.g., hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has designated "Comfort Measures."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should select "Limited Additional Interventions" or "Full Intervention" in Section B of this form.
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns and revise orders with the consent of the patient or authorized representative.
- If a health care provider or facility cannot comply with the orders because of policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility and provide appropriate care in the meantime.
- In the event the patient is hospitalized, the admitting physician should evaluate the patient and review the POST form. New orders may be recommended based on the patient's condition and their known preferences or, if unknown, the patient's best interest.

Reviewing Physician Orders for Scope of Treatment (POST)

This form should be periodically reviewed in the following circumstances:

- There is a substantial change in the patient's health status.
- The patient is transferred from one care setting or care level to another or the treating physician changes.
- The patient's treatment preferences change.

Voiding Physician Orders for Scope of Treatment (POST)

- A person with capacity, or the valid representative of a person without capacity, can void the POST orders at any time by any of the following: a signed and dated writing; physical cancellation or destruction; by another individual at the direction of the declarant or representative; or an oral expression. The revocation is effective upon communication to a health care provider.

A 2-page version of the form may be obtained from your nurse.

This form is also located on the website of www.in.gov/isdh.