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Sequence Number: <u>08-20-12</u>

Rule ID(s): 5289-5303

File Date: 8129112
Effective Date: 1/12612

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Department of Health	
Division:	Bureau of Health Licensure and Regulation	
Access	Division of Health Care Facilities	
Contact Person:	Diona E. Layden, Assistant General Counsel	
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Zip:	37243	
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Email:	Diona.l.ayden@tn.gov	

Revision Type (check all that apply):

X Amendment

x New

Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-08-01	Standards for Hospitals
Rule Number	Rule Title
1200-08-0115	Appendix I

Chapter Number	Chapter Title
1200-08-02	Standards for Prescribed Child Care Centers
Rule Number	Rule Title
1200-08-0214	Appendix

Chapter Number	Chapter Title
1200-08-06	Standards for Nursing Homes
Rule Number	Rule Title
1200-08-0616	Appendix I

Chapter Number	Chapter Title
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	Rule Title
1200-08-1015	Appendix I

Chapter Number	Chapter Title	
1200-08-11	Standards for Homes for the Aged	

Rule Number	Rule Title	
1200-08-1114	Appendix I	

Chapter Number	Chapter Title
1200-08-15	Standards for Residential Hospices
Rule Number	Rule Title
1200-08-1515	Appendix I

Chapter Number	Chapter Title
1200-08-24	Standards for Birthing Centers
Rule Number	Rule Title
1200-08-2414	Appendix I

Chapter Number	Chapter Title
1200-08-25	Standards for Assisted-Care Living Facilities
Rule Number	Rule Title
1200-08-2517	Appendix

Chapter Number	Chapter Title
1200-08-26	Standards for Home Care Organizations Providing Home Health Services
Rule Number	Rule Title
1200-08-2615	Appendix I

Chapter Number	Chapter Title
1200-08-27	Standards for Home Care Organizations Providing Hospice Services
Rule Number	Rule Title
1200-08-2715	Appendix I

Chapter Number	Chapter Title
1200-08-28	Standards for HIV Supportive Living Facilities
Rule Number	Rule Title
1200-08-28-,15	Appendix I

Chapter Number	Chapter Title
1200-08-32	Standards for End Stage Renal Dialysis Clinics
Rule Number	Rule Title
1200-08-3215	Appendix I

Chapter Number	Chapter Title
1200-08-34	Standards for Home Care Organizations Providing Professional Support Services
Rule Number	Rule Title
1200-08-3415	Appendix I

Chapter Number	Chapter Title
1200-08-36	Standards for Adult Care Homes – Level 2
Rule Number	Rule Title
1200-08-3618	Appendix I

Chapter Number	Chapter Title		
		The state of the s	

1200-08-35	Standards for Outpatient Diagnostic Centers
Rule Number	Rule Title
1200-08-3515	Appendix I

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Amendments

Rules 1200-08-01-.15 Appendix I, 1200-08-02-.14 Appendix, 1200-08-6-.16 Appendix I, 1200-08-10-.15 Appendix I, 1200-08-11-.14 Appendix I, 1200-08-15-.15 Appendix I, 1200-08-24-.14 Appendix I, 1200-08-25-.17 Appendix I, 1200-08-26-.15 Appendix I, 1200-08-27-.15 Appendix I, 1200-08-28-.15 Appendix I, 1200-08-32-.15 Appendix I, 1200-08-36-.18 Appendix I are amended by deleting the rules in their entirety and substituting the following forms, so that as amended, the new rules shall read as follows:

Appendix I

(1) Physician Orders for Scope of Treatment (POST) Form

(This space intentionally left blank)

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED					
F	Physician Orders for Scope of Treatment (POST)				e
This is a Physician Order Sheet based on the medical conditions a wishes of the person identified at right ("patient"). Any section completed indicates full treatment for that section. When need occurs, follow these orders, then contact physician.			tient"). Any section not	First Name/Middle Date of Birth	Initial
Section	CARDIO	PHI MONARY RESUSCI	TATION (CPR): Patient ha	e no pulse and/or i	not breathing
A Check One Box Only	☐ When no	<u>R</u> esuscitate (CPR) ot in cardiopulmonary arres	☐ <u>D</u> o <u>N</u> ot Attempt <u>R</u> es st, follow orders in B, C, and	uscitation (DNR/ no	o CPR) (<u>A</u> llow <u>N</u> atural <u>D</u> eath)
Section B Check One	Com route man sust	nfort Measures. Treat wit e, positioning, wound care ual treatment of airway ob taining treatment. Trans	struction as needed for com fer <u>only</u> If comfort needs o	o clean, warm, and d eve pain and suffering fort. Do not transfe cannot be met in cu	g. Use oxygen, suction and r to hospital for life- rrent location.
Box Only	card vent Trans	iac monitoring as indicate ilation. sfer to hospital if indicate	ed. Do not use intubation ed. Avoid intensive care.	n, advanced airway	dical treatment, IV fluids and interventions, or mechanical
	vent	ilation, and cardioversion a	care above. Use intubati as indicated. Transfer to h	ion, advanced airwoospital if indicated.	ay interventions mechanical include intensive care.
Section		structions:	w medical conditions:		
C Check One Box Only					
Section D Check One Box Only in Each Column	D feasible. Check One Sox Only in Each				tube pe for a defined trial period
Section	Discuss		The Basis for These Ord	ers is: (Must be cor	npleted)
E Must be Completed	☐ Patient/Resident ☐ Patient's preferences ☐ Health care agent ☐ Patient's best interest (patient lacks capacity or preferences unleaded in the care surrogate) ☐ Patient's preferences ☐ Patient's pref		y or preferences unknown)		
Physician Na (Print)		Physician Signature	•	Date	Physician Phone Number
Preferences h time if your pr preferences a	ave been e: eferences	xpressed to a physician and	nor, or Guardian/Health Ca l/or health care professional, o make your own health car	This form can be rev	riewed and updated at any rs should reflect your
Name (print)		Signature		Relationship (write	"self' if patient)
Surrogate		Relationship		Phone Number	
Health Care Pro Preparing Form	n Care Professional Preparer Title ring Form			Phone Number	Date Prepared

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

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.

(2) Advance Care Plan Form

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.					
	t the following person to make health care decisions for me. This includes any health care decision I ade for myself if able, except that my agent must follow my instructions below:				
Name: Address:	Phone #: Relation:				
appoint as alte	ent: If the person named above is unable or unwilling to make health care decisions for me, I ernate the following person to make health care decisions for me. This includes any health care ld have made for myself if able, except that my agent must follow my instructions below:				
Name: Address:	Phone #: Relation:				
My agent is al	so my personal representative for purposes of federal and state privacy laws, including HIPAA.				
When Effective if I have capacitonger have capacitons and the capacitons are supported by the	<u>ve</u> (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even city to make decisions for myself. ☐ I do not give such permission (this form applies only when I no apacity).				
adequate com	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given fort care and pain management. By marking "no" below, I have indicated conditions I would not be with (that to me would create an unacceptable quality of life).				
Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.				
Yes No	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	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	——————————————————————————————————————				
<u> </u>					
marked "no" al treatment be p	my quality of life becomes unacceptable to me (as indicated by one or more of the conditions bove) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" indicated treatment I do not want.				
Yes No	<u>CPR (Cardiopulmonary Resuscitation):</u> 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	<u>Life Support / Other Artificial Support:</u> 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	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	<u>Tube feeding/IV fluids:</u> 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.				

Please sign on page 2

Other manuactions, such	r as buriar arrangements, nos	oice care, etc.:
(Attach additional pages i	f necessary)	
Organ donation: Upon r	my death, I wish to make the fol	owing anatomical gift (mark one):
☐ Any organ/tissue	☐ My entire body	☐ Only the following organs/tissues:
☐ No organ/tissue donati	on.	
	SIGN	ATURE
be the person you appoin		ent adults or notarized. If witnessed, neither witness may and at least one of the witnesses must be someone who is
Signature:	(Patient)	Date:
Witnesses:	(Patient)	
	t who is not named as the age he patient's signature on this fo	
alternate. I am not marriage, or adoption portion of the patient's	t who is not named as the ager related to the patient by bl and I would not be entitled to estate upon his or her death u codicil or by operation of la signature on this form.	ood, any Signature of witness number 2 ider
This document may be no	tarized instead of witnessed:	
STATE OF TENNESSEE COUNTY OF		
personally known to me ("patient." The patient per	or proved to me on the basis of rsonally appeared before me a under penalty of perjury that the	named above. The person who signed this instrument is satisfactory evidence) to be the person who signed as the nd signed above or acknowledged the signature above as patient appears to be of sound mind and under no duress,
My commission expires: _		
•		Signature of Notary Public
WHAT TO DO WITH THIS	S ADVANCE DIRECTIVE	
	by to your physician(s)	accordible to others

- 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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

New Rule

Chapter 1200-08-35 Standards for Outpatient Diagnostic Centers

Chapter 1200-08-35 is amended by adding new rule 1200-08-35-.15 Appendix I to read as follows:

(1) Physician Orders for Scope of Treatment (POST) Form

(This space intentionally left blank)

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED					
P	Physician Orders for Scope of Treatment (POST)			Patient's Last Nam	e
This is a Physician Order Sheet based on the medical condition wishes of the person identified at right ("patient"). Any sectic completed indicates full treatment for that section. When need occur follow these orders, then contact physician.			ient"). Any section not	First Name/Middle	Initial
	Date of Birth				
Section A			TATION (CPR): Patient ha	·	-
Check One	□ When no	Resuscitate (CPR)	L Do Not Attempt Res t, follow orders in B, C, and	-	CPR) (<u>A</u> llow <u>N</u> atural <u>D</u> eath)
Box Only Section	413 5	gant the control of the Alice of the control of the		The same and the same and the same and the same	
В	Com route man	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for lifesustaining treatment. Transfer only if comfort needs cannot be met in current location.			
Check One Box Only	Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.				
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.				
	Other Instructions:				
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions: Union No Antibiotics Other Instructions:				
Section D Check One Box Only in Each Column					
Section	Discuss	ed with:	The Basis for These Ord	ers is: (Must be cor	npleted)
E Must be Completed	☐ Patient/Resident ☐ Patient's preferences ☐ Health care agent ☐ Patient's best interest (patient lacks capacity or preferences unknown in the patient lacks capacity or preferences unknown in the patient's best interest (patient lacks capacity or preferences unknown in the patient's best interest (patient lacks capacity or preferences unknown in the patient's preferences ☐ Health care surrogate ☐ Other: ☐ Other:		y or preferences unknown)		
Physician Na (Print)	ıme	Physician Signature	e (Mandatory)	Date	Physician Phone Number
Preferences had time if your pr	ave been e eferences	xpressed to a physician and	nor, or Guardian/Health Ca Vor health care professional. o make your own health car	This form can be rev	iewed and updated at any s should reflect your
Name (print)	int) Signature			Relationship (write "self" if patient)	
Surrogate	√	Relationship		Phone Number	
Health Care Pro Preparing Form		essional Preparer Title		Phone Number	Date Prepared

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

Directions for Health Care Professionals

Completing POST

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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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)

l, by my doctors	, hereby give these advance instructions on how I want to be treated and other health care providers when I can no longer make those treatment decisions myself.				
Agent: I want could have ma	t the following person to make health care decisions for me. This includes any health care decision I ade for myself if able, except that my agent must follow my instructions below:				
Name: Address:	Phone #: Relation:				
appoint as alte	ent: If the person named above is unable or unwilling to make health care decisions for me, I ernate the following person to make health care decisions for me. This includes any health care ld have made for myself if able, except that my agent must follow my instructions below:				
Name: Address:	Phone #: Relation:				
My agent is al	so my personal representative for purposes of federal and state privacy laws, including HIPAA.				
When Effectivity if I have capacillonger have capac	te (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even city to make decisions for myself. ☐ I do not give such permission (this form applies only when I no apacity).				
adequate com willing to live v	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given fort care and pain management. By marking "no" below, I have indicated conditions I would not be with (that to me would create an unacceptable quality of life).				
Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.				
Yes No	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	<u>Dependent in all Activities of Daily Living</u> : 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	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.				
marked "no" al treatment be p	my quality of life becomes unacceptable to me (as indicated by one or more of the conditions cove) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate rovided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" ndicated treatment I do not want. CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it				
Yes No	has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.				
Yes No	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	<u>Treatment of New Conditions:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.				
Yes No	<u>Tube feeding/IV fluids:</u> 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.				

Please sign on page 2 SS-7037 (October 2011)

Other instructions, such as burial arrangements, hospice co	are, 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 ☐ Or	nly the following organs/tissues:
☐ No organ/tissue donation.	
SIGNATUR	<u></u>
Your signature must either be witnessed by two competent ad be the person you appointed as your agent or alternate, and at not related to you or entitled to any part of your estate.	ults or notarized. If witnessed, neither witness may least one of the witnesses must be someone who is
Signature:(Patient)	Date:
(Patient) Witnesses:	
I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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 personally known to me (or proved to me on the basis of satisfa "patient." The patient personally appeared before me and sign his or her own. I declare under penalty of perjury that the patier fraud, or undue influence.	actory evidence) to be the person who signed as the ned above or acknowledged the signature above as
My commission expires:	
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Larry Arnold, MD				Χ	
Sylvia Burton	Х				
Paula Collier	Х				
Betsy Cummins	X				
Alex Gaddy	X				
Robert Gordon				Χ	
Jennifer Gordon-				Χ	
Maloney, DDS					
Luke Gregory				Χ	
Janice Hill	Χ				
Roy King, MD	X				
Jeff Lawrence, MD	Х				
Carissa Lynch	X				
Annette Marler	X				
John Marshall	X				
Jim Shulman	X				
James Weatherington	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the <u>Board for Licensing Health Care Facilities</u> on 05/02/2012, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 03/09/12
Rulemaking Hearing(s) Conducted on: (add more dates). 05/02/12
Date: June 21, 2912 Signature:
Name of Officer: Diona E. Layden Assistant General Counsel
Notary Public Signature: Department of Health Notary Public Signature: The Alexander William Notary Public Signature: The Al
Notary Public Signature: The local William
My commission expires on: $\frac{11/3}{1.5}$

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Robert E. Cooper, Jr.
Attorney General and Reporter

SS-7037 (October 2011)

Department of State Use Only

Filed with the Department of State on: 828112

Effective on: 11/26/12

Lushayell by

Tre Hargett Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Chris Puri spoke representing the Tennessee Health Care Association and stated the association supported the changes in the forms. Mr. Puri further stated that nursing homes, especially skilled nursing facilities certified by Medicare and Medicaid have tension in the survey process regarding advance directive forms. It was requested that the Board make a statement during the rulemaking stating the intent is to embrace the use of universal advance directives and increase the use of advance directive forms and ensure it is clear there may be inadvertent use of prior forms and this will not result in facility non-compliance.

The Board chose not to make a formal statement during the rulemaking.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

Regulatory Flexibility Analysis

- (1) The proposed revisions to the forms do not overlap, duplicate, or conflict with other federal, state, or local government rules.
- (2) The proposed revisions to the forms exhibit clarity, conciseness, and lack of ambiguity.
- (3) The proposed revisions to the forms give consideration to compliance and reporting requirements for small businesses.
- (4) There are no schedules or deadlines associated with the proposed revisions to the forms.
- (5) The proposed revisions to the forms give consideration to compliance and reporting requirements for small businesses.
- (6) The performance standards required in the proposed revisions to the forms are basic and do not necessitate the establishment of design or operational standards.
- (7) There are no unnecessary entry barriers or other effects in the proposed revisions to the forms that would stifle entrepreneurial activity or curb innovation.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

1. Types of small businesses that will be directly affected by the proposed rules:

Assisted-Care Living Facilities; Ambulatory Surgical Treatment Centers; Hospitals; Home Care Organizations Providing Home Health Services; Nursing Homes; HIV Supportive Living Centers; Homes for the Aged; Home Care Organizations Providing Professional Support Services; End Stage Renal Dialysis Clinics; Home Care Organizations Providing Hospice Services; Prescribed Child Care Centers; Residential Hospices; Birthing Centers; and Adult Care Homes.

2. Types of small businesses that will bear the cost of the proposed rules:

The proposed revisions to the forms should not result in a cost to small businesses.

3. Types of small businesses that will directly benefit from the proposed rules:

Unknown.

4. Description of how small business will be adversely impacted by the proposed rules:

Small businesses should not be adversely impacted by the proposed revisions to the rules.

5. Alternatives to the proposed rule that will accomplish the same objectives but are less burdensome, and why they are not being proposed:

The proposed revisions to the forms should not cause a burden to any small business.

6. Comparison with Federal and State Counterparts:

Unknown.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

These rule amendments and new rule are not expected to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The Physician Orders for Scope of Treatment (POST) form, a universal do not resuscitate order, and the Advance Care Plan form, an advance directive, are being amended. The forms are attached as an appendix to the rules for the various facility/entity types. With respect to the POST form, the form has been reformatted so that the signature lines are now on the first page of the form. With respect to the Advance Care Plan form, clarifying language has been added to the form to make the form more user-friendly and to clearly and accurately record the individual's healthcare wishes.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The applicable law is contained in T.C.A. § 68-11-209 (Rules and regulations governing operation – Adoption by board); T.C.A. § 68-11-224(i)(1) (Withholding of resuscitative services – Regulations); and T.C.A. § 68-11-1805 (Model forms – Rules and regulations).

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons, organizations, corporations, and entities affected by these forms will be those who execute end of life directives and/or who assist individuals execute end of life directives. No one has urged rejection of the amendments to the forms.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

Tenn. Op. Atty. Gen. No. 05-093, 2005 WL 1839873 (Tenn.A.G.) – Authority Under the Tennessee Health Care Decisions Act

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The amendments to the forms should result in neither a positive nor a negative fiscal impact.

 (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

I, as well as Vincent Davis, Director of the Division of Health Care Facilities, possess substantial knowledge and understanding of the rule.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

I, as well as Vincent Davis, Director of the Division of Health Care Facilities, will explain the rules at a scheduled meeting of the Government Operation Committee.

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Diona E. Layden, Assistant General Counsel, Tennessee Department of Health, 220 Athens Way, Suite 210, Nashville, TN 37243, (615) 741-1611, <u>Diona.Layden@tn.gov</u>; Vincent Davis, Director, Health Care Facilities,

227 French Landing Drive, Suite 501, Nashville, TN 37243, (615) 741-7221, Vincent Davis@tn.gov

(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

I will provide any additional information requested by the Government Operations Committee.

deferral of elective admission patients and also for the early transfer or discharge of some current patients if it appears that the number of casualties will exceed available staffed beds.

- 3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to staff who would be assigned non-routine duties during these types of emergencies. Familiarization information shall be included in employee orientation sessions and more detailed instruction must be included in continuing education programs. Records of orientation and education must be maintained for at least three (3) years.
- 4. At least one drill shall be conducted each year for the purpose of educating staff, resource determination, and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.
- 5. As soon as possible, actual community emergency situations that result in the treatment of more than twenty (20) patients, or fifteen percent (15%) of the licensed bed capacity, whichever is less, must be documented. Actual situations that had education and training value may be substituted for a drill. This includes documented actual plan activation during community emergencies, even if no patients are received.
- (c) Emergency Planning with Local Government Authorities.
 - All hospitals shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
 - 2. Each hospital must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.
 - A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. **Administrative History:** Original rule filed March 18, 2000; effective May 30, 2000.

1200-08-01-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

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.

Section	CARDIOPULMONARY RE	SUSCITATION	(CPR): Patient has r	o pulso a	nd/or is not breathing.	
	☐ Resuscitate (CPR)				Resuscitate (DNR/no-CPR)	
Check One Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.					
Section-B	MEDICAL-INTERVENTION	VS. Patient has	pulse and/ <u>or</u> is breati	ning.		
Check One Box Only	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.					
	ventilation, and cardic	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:	***************************************		***************************************	No. of the Control of	
Section	ANTIBIOTICS Treatment	for new medica	conditions:			
	☐ Ne Antibiotics					
Check One Box Only	☐ Antiblotics					
	Other Instructions:					
Section D	MEDICALLY ADMINISTER medically feasible.	ED FLUIDS ANI	O NUTRITION. Oral	fluids and	nutrition must be offered if	
Check One Box Only in	No IV fluids (provide oti	ner-measures to	assure comfort)	H-No	feeding tube eding tube for a defined trial period	
Each Column	Uther Instructions:	licated			eding tube long term	
Section	Discussed with:		The Basis for Thes	a Ordara i	is: (Must-be-completed)	
E.	☐ Patient/Resident ☐ Health care agent		Patient's prefer	ences	fient lacke capacity or preferences unknown)	
Must be Completed	☐ Court-appointed guardid☐ Health care surrogate	3n	Medical Indicat	ions	nonnadia copocity or protosoticos discretionis	
	Parent of minor		(Other)			
	Other: Physician Name (Print)	(Spacify)	Obvoicion Oboso M		Office Use Only	
	Physician Signature (Manda	tana)		иннын	Office Use Only	
	rnyololan Signature (Manus	story)	Date			
COP	Y OF FORM SHALL ACC	OMPANY PAT	IENT WHEN TRAF	JSFERR	ED OR DISCHARGED	
1.11-9						
Signature of Pa	tient, Parent of Minor, or Gua	rdian/Health Ca	re-Representative			
Significant theugoresion	ght has been given to life-sus al(s). This document reflects	itaining treatmer -those-treatment	t. Preferences have preferences.	been exp	ressed to a physician and/or health	
(If signed by sur	rogale, preferences express	ed must reflect p	atient's wishes as be	st unders	tood by surrogate.)	
Signature	Na	me (print)			ship (write "self" if patient)	
Contact Infor	mation					
Surregate		Relationship			Number	

Health Care Professional Preparing	Preparer Tille	Phone Number	Date Prepared
Form	oparo, . iitio	1 110110 Hamber	valo i roparoa
T OTTE			
n:	nations for Unally Ones Defend	<u> </u>	

Directions for Health Care Professionals

Completing POST

- Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.
- POST must be signed by a physician to be valid. Verbal orders are acceptable with follow up signature by physician in accordance with facility/community policy.
- Photocopies/faxes of signed POST forms are legal and valid.

Using POST

- Any incomplete section of POST implies full treatment for that section.
- No defibrillator (including AEDs) should be used on a person who has chosen *Do Not
- Attempt-Resuscitation*.
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone
- -with "Comfort Measures Only", should be transferred to a setting able to provide
- comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen
- Comfort Measures Only".
- Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids
- —should indicate "Limited Interventions" or "Full Treatment".
- A person with capacity, or the surrogate of a person without capacity, can request
- -alternative treatment.

Reviewing POST

- This POST should be reviewed If:
- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FO	RM SHALL ACCOMPANY PATIEN	T WHEN TRANSFERRED OR DISCHARGED	
Physician Orders fo	Scope of Treatment (POST)	Patient's Last Name	

wishes of to completed in	he persor idicates ful	<u>identified at right ("pa</u>	e medical conditions and tient"). Any section not n. When need occurs, first	First Name/Middle Date of Birth	Initial
Section A Check One Box Only	<u>CARDIC</u>	PULMONARY RESUSCI Resuscitate (CPR)	TATION (CPR): Patient ha Do Not Attempt Results, follow orders in B, C, and	uscitation (DNR/ no	s not breathing. o CPR) (Allow Natural Death)
Section B	☐ Con rout man	nfort Measures. Treat wit e, positioning, wound care ual treatment of allway ob	ient has pulse and/or is br th dignity and respect. Keep and other measures to relie struction as needed for com fer only if comfort needs o	o clean, warm, and deve pain and suffering fort. Do not transfe	g. Use oxygen, suction and er to hospital for life-
Check One Box Only	<u>card</u> vent	iac monitoring as indicat ilation.	ions. Includes care descrited. Do not use intubationed. Avoid intensive care.	bed above. Use me n, advanced airway	edical treatment, IV fluids and interventions, or mechanical
	<u>vent</u>	Treatment. Includes of lation, and cardioversion of structions:	care above. Use intubati as indicated, Transfer to ho	ion, advanced airw ospital if indicated.	ay interventions mechanical include intensive care.
Section C Check One Box Only	□ No A	Antibiotics biotics Other In	w medical conditions:		
Section D Check One Box Only in Each Column	feasible. No l' ly flu ly flu ly flu			☐ No feeding ☐ Feeding tul	AMONORONOSE
Section E Must be Completed	☐ Health☐ Court-☐ Health	t/Resident i care agent appointed guardian i care surrogate t of minor	The Basis for These Orde ☐ Patient's preferences ☐ Patient's best interest (☐ Medical Indications ☐ (Other)		npleted) y or preferences unknown)
Physician Na (Print)	ıme	Physician Signature	(Mandatory)	Date	Physician Phone Number
Freferences had me if your pr	ave been ex eferences	pressed to a physician and	nor, or Guardian/Health Ca l/or health care professional. o make your own health care	This form can be rev	lewed and updated at any rs should reflect your
Freferences had me if your pr	ave been ex eferences	oressed to a physician and change. If you are unable t	l/or health care professional. o make your own health care	This form can be rev	rs should reflect your
Freferences had me if your proferences a	ave been ex eferences	opressed to a physician and change. If you are unable t erstood by your surrogate.	l/or health care professional. o make your own health care	This form can be revered the corde	rs should reflect your

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

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.

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

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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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or notarized.	
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:	
Name:Phone #:Relation:	
Address:	
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint a alternate:	38
Name:Phone #:Relation:	
Address:	
Quality of Life;	
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):	
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.	
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.	
 Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help. 	
End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.	
<u>Treatment:</u>	
If my quality of life becomes unacceptable to me and my condition is Irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.	
Yes No 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 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 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.	
Tube feeding/IV fluids: Use of tubes to deliver feed and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.	

(Rule 1200-08-01-.15, continued) Other Instructions, such as burial arrangements, hospice care, etc.: (Attach additional pages if necessary) Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one): SIGNATURE Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not

∍ign ature: -					
	(Patient)	 	W	······	
	(and my				
Alitnesses:					

lam 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	Signature of witness number 2
- 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.	

This document may be notarized instead of witnessed:

related to you or entitled to any part of your estate.

STATE OF TENNESSEE COUNTY OF

Lam 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.

My commission expires: Signature of Notary Public

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

ADVANCE CARE PLAN (Tennessee)

	(Tennessee)
l, treated by my decisions mys	, hereby give these advance instructions on how I want to be / doctors and other health care providers when I can no longer make those treatment elf.
Agent: I want decision I coul	the following person to make health care decisions for me. This includes any health care decisions for me.
Name: Relation:	Phone #:
Address:	
l appoint as al	ent: If the person named above is unable or unwilling to make health care decisions for me, ternate the following person to make health care decisions for me. This includes any health could have made for myself if able, except that my agent must follow my instructions.
Name:	Phone #: Relation:
Address:	
My agent is a HIPAA.	lso my personal representative for purposes of federal and state privacy laws, including
time, even if I	re (mark one): I give my agent permission to make health care decisions for me at any have capacity to make decisions for myself. I do not give such permission (this form nen I no longer have capacity).
adequate com	: By marking "yes" below, I have indicated conditions I would be willing to live with if given fort care and pain management. By marking "no" below, I have indicated conditions I would be live with (that to me would create an unacceptable quality of life).
☐ ☐ Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes No	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not
Yes No	recognize loved ones or cannot have a clear conversation with them. 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	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.

<u>Treatment:</u> 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.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	has stopped. Usually this involves electric shock Life Support / Other Artificial Support: Continuous and other equipment that helps the lungs, heart Treatment of New Conditions: Use of surger new condition but will not help the main illness.	y, blood transfusions, or antibiotics that will deal with a food and water to a patient's stomach or use of IV
Please sign or	ı page 2	Page 1 of 2
Other instruct	ions, such as burial arrangements, hospice c	are, etc.:
(Attach addition	nal pages if necessary)	
Organ donatio	n: Upon my death, I wish to make the following	anatomical gift (mark one):
☐ Any organ/tis	ssue	ly the following organs/tissues:
☐ No organ/tiss	sue donation.	
may be the per	SIGNATURE must either be witnessed by two competent adurson you appointed as your agent or alternate, s not related to you or entitled to any part of your	and at least one of the witnesses must be
Signature:		Date:
Witnesses:	(Patient)	
	etent adult who is not named as the agent or eitnessed the patient's signature on this form.	Signature of witness number 1
alternate. I marriage, or portion of the any existing	etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I patient's signature on this form.	Signature of witness number 2
This document i	may be notarized instead of witnessed:	
STATE OF TEN	INESSEE	

(Rule 1200-08-0115,	continued)
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.

My commission expires:	
	Cianatura of Natan, Dublia
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

Inventory F	Results:			
	indicated - medical confirmation	of noninfectious status required		
	not indicated - no further action	necessary		
	Signature:			
	Date Completed:			
Medical Co	··· P ····· · · · · · · · · · · · · · ·			
Weulcai Co				
	confirmation of noninfectious sta			
	Signature:			
	Date Received:	•		
/45		PPENDIX I		
(1)	Physician Orders for Scope of Treati	ment (POST) Form		
COPY	OF FORM SHALL ACCOMPANY PA	HENT-WHEN TRANSFERRED OR DISCHARGED		
for	Physician Orders - Scope of Treatment (POST)	Pallent's Last Name		
	. ,	First Name/Middle-Initial		
conditions and	cian Order Sheet based on the medical wishes of the person identified at right y section not completed indicates full	The state of the s		
treatment for the	y section not completed indicates full nat section. When need occurs, <u>first</u> follow nen contact physician.	Date of Sirth		
Section		CPR): Patient has no pulse <u>and/or is not breathing.</u>		
A		□ Do Not Attempt Resuscitate (DNR/no CPR)		
Check One Bex Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.			
Section B	MEDICAL INTERVENTIONS. Patient has p	ulse and/ <u>or</u> is breathing.		
	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering.			
Check One	Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.			
Box Only	Limited Additional Interventions Includes care described above. Use medical treatment IV fluids and			
	cardiac menitoring as indicated. Do not use intubation, advanced alrway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.			
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.			
	Other Instructions:			
Section	ANTIBIOTICS - Treatment for new medical	senditions:		
G	and his Antibutation			

edicina and management of the Asia Committee	The second of a continue	,					
Check One	☐ Antibiotics						
Box Only	Other Instructions:						
Section D	MEDICALLY ADMINISTERED feasible.	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.				medically	
Check One Bex Only in Each Column	☐ IV fluids for a defined trial ☐ IV fluids long-term if indica	No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term				period	
Section E Must be Completed	Discussed with: Patient/Resident Health care agent Court appointed guardian Health care surregate Parent of minor Other:	(Specify)	The Basis for Their Patient's preference Patient's best in Medical indicated (Other)	rences Interest (pa Illons	iliant laeka cap	acity or preferences ur	iknown)
	Physician Name (Print)		Physician Phone N	lumber	Office Us	e Only	
	Physician Signature (Mandato	ry)	Date				
Signature of Pa Significant thou health care pro-	PY OF FORM SHALL ACCO	ne le si lan/Health Ca lning-treatmer ects-those-tre	e (IA) alla gracialise re Representative it. Preferences have alment preferences.	et unders	ressed to a	a physician and/o	F
- Orginatoro	indille	(pilli)		- Keiston	enip (wnte	seir ir patient)	
Contact Information Surrogate Relationship			Phone Number				
Health Care Professional Preparing Preparem		Preparer Titl	e	Phone-I	Vumber	Date Prepared	a
	Direction	ons for Health	Care Professionals	<u> </u>			\dashv
Completing POST Must be completed by a health care professional based on patient preferences, patient best interest, and medical							
indications. POST must be accordance v	e-signed by a physician to be va vith-facility/community policy.	ilid. Verbal-or	ders are acceptable	with follow	'-up-signati	ire by physician i	n
Photocopies/f	axes of signed POST forms are	legal and valid	d. .				
Using POST							
- Any incomplet	re-section of POST implies full tr	eatment for th	eat section.				
No defibrillator Attempt Resur	r (Including AEDs) should be use selfation*	ed on a perso	n who has chosen °C	o-Net			
—Oral fluids and nutrition must always be offered if medically feasible.							

When comfort cannot be achieved in the current setting, the person, including someone — with "Comfort Measures Only", should be transferred to a setting able to provide — comfort (e.g., treatment of a hip fracture).
— IV medication to enhance comfort may be appropriate for a person who has chosen —"Comfort Measures Only".
Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".
—A person with capacity, or the surrogate of a person without capacity, can request —alternative treatment.
Reviewing POST
This POST should be reviewed if:
(1) The patient is transferred from one care setting or care level to another, or (2) There is a substantial change in the patient's health status, or (3) The patient's treatment preferences change.
Draw line through sections A through E and write "VOID" In large letters if POST is replaced or becomes invalid.
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(1) Physician Orders for Scope of Treatment (POST) Form

	A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	N TRANSFERRED OR DISCHARGED		
· · · · · · · · · · · · · · · · · · ·	Physician Orders for Scope of Treatment (POST)	Patient's Last Name		
wishes of to completed in	Physician Order Sheet based on the medical conditions and the person identified at right ("patient"). Any section not adicates full treatment for that section. When need occurs, first orders, then contact physician.	First Name/Middle Initial		
		Date of Birth		
<u>Section</u>	CARDIOPULMONARY RESUSCITATION (CPR): Patient has	s no pulse and/or is not breathing.		
A Check One	Propositoto (CPR)			
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.			

\		Appoint it, continued	· · · · · · · · · · · · · · · · · · ·		
Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.				
	□ Full vent Other In:	ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.			
Section C Check One Box Only	□ No / □ Anti		er Instructions:		
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible. □ No IV fluids (provide other measures to assure comfort) □ No feeding tube □ IV fluids for a defined trial period □ Feeding tube for a defined trial period □ IV fluids long-term if indicated □ Feeding tube long-term Other Instructions:				
Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify) ☐ The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical Indications ☐ (Other)				
Physician Na (Print)	IME	Physician Signature	e (Mandatory)	Date	Physician Phone Number
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Freferences have been expressed to a physician and/or health care professional. This form 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)				
\$urrogate	Relationship		Phone Number		
Health Care Pro Preparing Form	eparing Form Preparer Title			Phone Number	Date Prepared
	IIPAA PER	MITS DISCLOSURE OF I	POST TO OTHER HEALTH	CARE PROFESSIO	DNALS AS NECESSARY

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 freatment.

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Compo of their own choosin notarized.	etent adults and emancipated mine g. To be legally binding, the Adva	rs may give advance instructions ice Care Plan must be signed and	using this form or any form l <u>either</u> witnessed or
i,my doctors and other	, hereby ar health care providers when I	give these advance instruction can no longer make those trea	ns on how I want to be treated by atment decisions myself.
Agent: I want the fo	llewing person to make health	care decisions for me:	
Name:	Phone #:	Relation:	
Address:			
Alternate Agent: If t	he person named above is una	ble or unwilling to make health	n care decisions for me, I appoint a
Name:	Phone#:	Relation;	
Adalumm			

(Rule 1200-08-02-Appendix I, continued)

Quality of Life:				
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):				
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.				
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.				
 Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help. 				
 End Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation. 				
<u>Treatment:</u>				
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.				
Yes No CPR (Cardiopulmonary Resuscitation); To make the heart beat again and restore breathing after it has stopped. Usually this involves electric sheck, chest compressions, and breathing assistance.				
Yes No 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 Will deal with a new condition but will not help the main illness.				
Yes No Tube feeding/IV fluids: Use of tubes to deliver feed and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.				
Other instructions, such as burial arrangements, hospice care, etc.:				
(Attach additional pages if necessary)				
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):				
☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:				
SIGNATURE				
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.				
Signature: DATE:				
it and the state of the state o				

(Rule 1200-08-02-Appendix I, continued)

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 eignature on this form.	
This document may be notarized instead of witnessed:	
STATE OF TENNESSEE GOUNTY OF	•
I am a Notary Public in and for the State and County named above. The person who signed this instrumpersonally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signates "patient". The patient personally appeared before me and signed above or acknowledged the signature or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no fraud, or undue influence.	ined as the above as bis
My commission expires:	
Signature of Notary Public	
WHAT TO DO WITH THIS ADVANCE DIRECTIVE	
 Previde 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 	
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2 Acknowledgement to Project GRACE for inspiring the development of this form.	005
(2) Advance Care Plan Form	
ADVANCE CARE PLAN (Tennessee)	
l, hereby give these advance instructions on how I treated by my doctors and other health care providers when I can no longer make those decisions myself.	want to be treatment
Agent: I want the following person to make health care decisions for me. This includes any he decision I could have made for myself if able, except that my agent must follow my instructions	alth care below:
Name: Phone #:	
Relation:	
Address:	
Alternate Agent: If the person named above is unable or unwilling to make health care decision and alternate the following person to make health care decision.	ons for me,

l appoint as alternate the following person to make health care decisions for me, 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:

1200-08-06-.16 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

COPY C	OF FORM SHALL ACCOMPANY PAI	TENT	WHEN TRANSFE	RRED OR DISCHARGED		
Physician Orders			nt's Last Name	(-1)		
for Scope of Treatment (POST)						
This is a Phys	iclan Order Sheet based on the medical	First	First Name/Middle-Initial			
conditions and	i wishes of the person identified at right ry section not completed indicates full					
treatment for t	hat section. When need occurs, first follow	Date	of Birth			
	then contact physician.					
Section -A	CARDIOPULMONARY RESUSCITATION (CPR):	CPR): Patient has no pulse <u>and/or</u> is not breathing.			
Check One	Resuscitate (CPR)		— <u>Do N</u> ot Attempt <u>E</u>	(esuscitate (DNR/no-CPR)		
Box-Only	When not in cardiopulmonary arrest, follow	orders-	n B, C, and D.			
Section B	MEDICAL INTERVENTIONS. Patient has a	oulse ar	id/ <u>or</u> is breathing.			
	☐ Comfort Measures Treat with dignity a	nd resp	ect. Keep clean, warm	and dry		
	Use medication by any route, positionic Use oxygen, suction and manual treatr	ng, wou	nd care and other mea	sures to relieve pain and suffering.		
Check One Box Only	to hospital for life-sustaining treatment.	Trans	fer <u>only</u> if comfort need	s cannot be met in current location.		
DUX-GIIIY	Limited Additional Interventions Include	es care	described above. Use	medical treatment, IV fluids and		
	cardiac monitoring as indicated. Do no ventilation. Transfer to hospital if indicated	it use in ated. A	tubation, advanced ain void intensive care.	vay interventions, or mechanical		
				u interceptions machanism		
F 6 6 6 6 8	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						
	☐-No-Antibiotics					
Check One	Weekle Company of the					
POX OHLY	Bex Only Other Instructions:					
Section	MEDICALLY ADMINISTERED FLUIDS AND	NUTR	ITION Oral fluids and	nutrition must be offered if		
Ð	medically feasible.					
Check One	= 1.0 1.0 10 00 00 00 00 00 00 00 00 00 00 00 00					
Box Only in Each	☐ IV fluids for a defined trial period ☐ IV fluids long term if Indicated		——————————————————————————————————————	ling tube for a defined trial period ling tube long-term		
Column	Column Other					
	Instructions:					
Section	Discussed with:			s: (Must be completed)		
■ Patient/Resident □ Patient's pre				fient lacks capacity or preferences unknown)		
Must be Court-appointed guardian Medical indicatio				The state of the s		
Completed Health care-surrogate (Other)						
Other: (Specify)						
	Physician Name (Print)	Physic	sien Phone Number	Office Use Only		
	Physician Signature (Mandatory)		Date			
	- /					

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

				April 1888 April
Signature of Patient, Parent of Minor, or of Significant thought has been given to life	Suare	dian/Health Care Representative	haan ayaraa adda a	
health care professional(s). This docume	int re	flecis those treatment preferences.	neau <u>exblessed (e e</u>	- рпуыскан апалог
(If signed by surrogate, preferences expr	38886	i must reflect nationt's wishes as he	et understood by sur	rocate)
Signature	Nam	ne (print)	Relationship (write	self if patient)
Contact Information			I	
Surrogate		Relationship	Phone Number	1712
Health Care Professional Preparing	\neg	Preparer Title	Phone Number	Date-Prepared
Form		•		
	<u> </u>	tions for Health-Care Professionals		
Completing POST				
Must be completed by a health care prointing indications.	fess	onal based on patient preferences, i	patient best interest,	and medical
POST must be signed by a physician to accordance with facility/community poli	-be-v cy-	ralid. Verbal orders are acceptable t	with-follow-up-signatu	ıre-by-physician in
-Photocoples/faxes of signed POST form	1 5-2 76	e 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 Net Attempt Resuscitation".				
—Oral fluids and nutrition must always be	<u>offer</u>	ed_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 v	write "VOID" in large letters if POST	is replaced or becom	ies invalid.

December, 2009 (Revised)

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(1) Physician	Orders	for	Scope	of Treatment	(POST) Form	t

<u>P</u>	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHE	N TRANSFERRED OR DISCHARGED		
Editor)	Physician Orders for Scope of Treatment (POST)	Patient's Last Name		
wishes of the dompleted in	hysician Order Sheet based on the medical conditions and he person identified at right ("patient"). Any section not adicates full treatment for that section. When need occurs, first orders, then contact physician.			
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient ha	as no pulse and/or <u>is not breathing.</u>		
<u>A</u> Check One Box Only	☐ Resuscitate (CPR) ☐ Do Not Attempt Res When not in cardiopulmonary arrest, follow orders in B, C, and	uscitation (DNR/ no CPR) (Allow Natural Death)		
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is be Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of the limited Additional International Institute Communications.	p clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and office of transfer to hospital for lifecannot be met in current location.		
<u>Check One</u> <u>Box Only</u>	Limited Additional Interventions. Includes care descricardiac monitoring as indicated. Do not use intubation ventilation. Transfer to be private interest A valid interest as a second and interest as a second and interest.	n, advanced airway interventions, or mechanical		
/	Transfer to hospital if indicated. Avoid intensive care.			
☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.				
and the second s	•			
	Other Instructions:			
Section C	Other Instructions: ANTIBIOTICS – Treatment for new medical conditions:			
Check One Box Only	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral for	luids & nutrition must be offered if medically		
Check One Box Only Section D Check One	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral feasible. No IV fluids (provide other measures to assure comfort)	fluids & nutrition must be offered if medically No feeding tube		
Check One Box Only Section D	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral feasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period	 □ No feeding tube □ Feeding tube for a defined trial period 		
Check One Box Only Section D Check One Box Only in Each Column	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral teasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions:	 □ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term 		
Check One Box Only Section D Check One Box Only in Each	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral feasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident Health care agent The Basis for These Ord Patient's preferences	 □ No feeding tube □ Feeding tube for a defined trial period 		
Check One Box Only Section Dheck One Box Only in Each Column Section	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral feasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident The Basis for These Ord Patient's preferences	□ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term lers Is: (Must be completed)		
Check One Box Only Section DCheck One Box Only in Each Column Section E Must be	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions: MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral of feasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident Health care agent Court-appointed guardian Health care surrogate Parent of minor Other: (Specify)	□ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term lers Is: (Must be completed)		

I time it vour breterei	nces change, it vou are unable to make :	th care professional. This form can be reviewed and updated at any your own health care decisions, the orders should reflect your
Name (print)	Signature	Relationship (write "self" if patient)
Surrogate	Relationship	Phone Number
Health Care Profession Freparing Form	nal Preparer Title	Phone Number Date Prepared

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

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.
WEST PROPERTY AND	Programme and the second secon
(2) Advanc	e Care Plan Form
•	ADVANCE CARE PLAN
Instructions: Compete their own choosing. T	ent adults and emancipated minors may give advance instructions using this form or any form of to be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.
l,doctors and other hea	hereby give these advance instructions on how I want to be treated by my alth care providers when I can no longer make those treatment decisions myself.
Agent: I want the follo	owing person to make health care decisions for me:
Name:	Phone #: Relation:
Address:	
Alternate Agent: If the alternate:	person named above is unable or unwilling to make health care decisions for me, I appoint as
Name:	Phone #: Relation:
Address:	
Quality of Life:	
I want my doctors to h life that is unacceptabl items as you want);	elp me maintain an acceptable quality of life including adequate pain management. A quality of le to me means when I have any of the following conditions (you can check as many of these
Permanent U surroundings	ncenscious Condition: I become totally unaware of people or with little chance of ever waking up from the coma.
Permanent C	onfusion: I become unable to remember, understand or make to not recognize loved ones or cannot have a clear conversation with them.
or move by m	<u>all Activities of Dally Living:</u> I am no longer able to talk clearly syself. I depend on others for feeding, bathing, dressing and walking. For any other restorative treatment will not help.
full treatment: treatment; chi	nesses: I have an illness that has reached its final stages in spite of Examples: Widespread cancer that does not respond anymere to renic and/or damaged heart and lungs, where exygen needed most of activities are limited due to the feeling of suffocation.
Treatment:	
If my quality of life become that medically appropriate of means I DO NOT	emes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct at the treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking want the treatment.
Yes No	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	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.
woen ween	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that
Yes No	will deal with a new condition but will not help the main illness.
	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach
Yes No	or use of IV fluids into a vein which would include artificially delivered nutrition and
	hydration.
Other instructions, suc	rh as burial arrangements, hospice care, etc.:
(Attach additional page	es if necessary)
Organ denation (option	nal): Upon my death, I wish to make the following anatomical gift (please mark one);
F-1 A	growing & A. C.
☐ Any organ/tissue	☐ My entire body ☐ Only the following organs/tissues:
	SIGNATURE
Your signature should be the person you app to you or entitled to an	either be witnessed by two competent adults or notarized. If witnessed, neither witness shoul cinted as your agent, and at least one of the witnesses should be someone who is not related y part of your estate.
Signature:	DATE:
O'gratero:	(Patient)
	(: 400m)
Witnesses:	
1. I am a competent a	dult who is not named as the agent.
witnessed the patie	ent's signature on this form. Signature of witness number 1
0 1	
∠. ⊢am a competent a	dult who is not named as the agent.
- l-am not related to t	he patient by blood, marriage, or Signature of witness number 2
— agebrien and I wont	d not be entitled to any portion of
the patient's estate-	upon his or her death under any existing
- Will or codicil or by c	pperation of law. I witnessed the
— patient's signature of	in this form.
This document may be	notarized instead of witnessed:
STATE OF TENNESSE	<u>==</u>
COUNTY OF	s \$40
ALL PARTY AND A STATE OF THE ST	Address of the state of the sta
personally known to me "patient". The patient p	and for the State and County named above. The person who signed this instrument is e (or proved to me on the basis of satisfactory evidence) to be the person who signed as the rersonally appeared before me and signed above or acknowledged the signature above as his nder penalty of perjury that the patient appears to be of sound mind and under no duress, se.
My commission expires	
) sommoderovinge	Signature of Notary Public
	orginature of motory i tibile

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)
l, , 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).
Yes No Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes No 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 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 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.

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	e (that is, it will not improve). I direct that
medically appropriate treatment be provided as follows. By many	arking "ves" below. I have indicated
treatment I want. By marking "no" below, I have indicated trea	atment I do not want.
☐ ☐ CPR (Cardiopulmonary Resuscitation): To r	make the heart beat again and restore breathing after it
Yes No has stopped. Usually this involves electric short	ck, chest compressions, and breathing assistance.
	inuous use of breathing machine, IV fluids, medications,
Yes No and other equipment that helps the lungs heart	t, kidneys, and other organs to continue to work.
☐ ☐ Treatment of New Conditions: Use of surger	y, blood transfusions, or antibiotics that will deal with a
Yes No new condition but will not help the main illness.	The state of the s
☐ ☐ Tube feeding/IV fluids: Use of tubes to delive	r food and water to a patient's stomach or use of IV
Yes No fluids into a vein, which would include artificially	delivered nutrition and hydration.
Please sign on page 2	Doga 4
of 2	Page 1
Other instructions, such as burial arrangements, hospice c	are, etc.:
(Attach additional pages if necessary)	
Organ donation: Upon my death, I wish to make the following	anotamical wife (manula mun)
organ donation. Opon my death, I wish to make the following	ariatomicai girt (mark one):
☐ Any organ/tissue ☐ My entire body ☐ On	nly the following organs/tissues:
☐ No organ/tissue donation.	
HO Organnissue donation.	
SIGNATURE	
(Company of the state of the st	
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 alter	nate, and at least one of the witnesses must
be someone who is not related to you or entitled to any part of yo	our estate.
Signature:	Date:
(Patient)	
Witnesses:	
1. I am a competent adult who is not named as the agent or	
alternate. I witnessed the patient's signature on this form.	Cian above at the state of
atternate. I with cooca 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 or	
alternate. I am not related to the patient by blood,	
marriage, or adoption and I would not be entitled to any	Signature of witness number 2
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.

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.
My commission expires:
Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. **Administrative History:** Original rule filed November 22, 1996; effective August 27, 1997. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003.

1200-08-10-.15 APPENDIX I

_(1) Physician Orders for Scope of Treatment (POST) Form

COPY-C	F FORM SHALL-ACCOMPANY PAT	IENT-WHEN-TRANSFERRED-OR-DISCHARGED				
f ←	Physician Orders	Patient's Last Name				
This is a Phys	ician Order Sheet based on the medical	First-Name/Middle-Initial				
("patient"). Ar treatment for t	ny section not completed indicates full that section. When need occurs, <u>first</u> follow then contact physician.	Date of Birth				
Section A		I CPR): Patient has no pulse <u>and/or</u> is not breathing.				
Check One	☐ Resuscitate (CPR)					
Box Only	When not in cardiopulmonary arrest, follow-	erders in B, C, and D.				
Section B	MEDICAL INTERVENTIONS. Palient has p	uise and/ <u>or is breathing.</u>				
Check-One Box-Only	☐ 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 hespital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.					
	Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac menitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.					
	Full Treatment. Includes care above. Use intubation, advanced already interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include Intensive care. Other Instructions:					

Section C	ANTIBIOTICS - Treatment for new medical conditions:					
	☐ Ne-Antibiotics					
Check One Box Only	☐ Antibiotics					
	Other Instructions:					
Section D	MEDICALLY ADMINISTERED FLUIDS AND medically feasible.	NUTRITION. Oral fluids and nutrition must be offered if				
Check One Box Only in Each Column	☐ No IV fluids (provide other measures to a ☐ IV fluids for a defined trial period ☐ IV fluids long-term if indicated ☐ Other Instructions:	Feeding tube for a defined trial period Feeding tube long-term				
0.20						
Section E	Discussed with: Patient/Resident Health care agent	The Basis for These Orders Is: (Must be completed) Patient's preferences Retient's preferences				

(Rule 1200-08-10-.15 continued) ☐ Medical indications Must be Court-appointed guardian Completed Health care surrogate Parent of minor (Other) Other: (Specify) Physician Name (Print) Physician Phone Number Office Use Only Physician Signature (Mandatory) Date COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. <u>(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)</u> Signature Name (print) Relationship (write "self" if patient) Contact Information Surrogate Relationship Phone Number Health Care Professional Preparing Preparer Title Phone Number Date-Prepared Form 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 AEOs) should be used on a person who has chosen "Do Not -Attempt Resuscitation". Oral fluids and nutrition must always be offered if medically feasible. When comfort cannot be achieved in the current setting, the person, including someone -- with "Comfort Measures Only", should be transferred to a setting able to provide -comfort (e.g., treatment of a hip fracture). -IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only". Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids - should indicate "Limited Interventions" or "Full Treatment". A person with capacity, or the surrogate of a person without capacity, can request -alternative-treatment. Reviewing POST This POST should be reviewed if:

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

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(1) Physician Orders for Scope of Treatment (POST) Form

Λ	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	! TRANSFERRED OR DISCHARGED				
	Physician Orders for Scope of Treatment (POST)	Patient's Last Name				
wishes of the	nysician Order Sheet based on the medical conditions and the person identified at right ("patient"). Any section not dicates full treatment for that section. When need occurs, first	First Name/Middle Initial				
tpilow these o	orders, then contact physician.	Date of Birth				
Section A	CARDIOPULMONARY RESUSCITATION (CPR): Patient ha	s no pulse and/or is not breathing.				
A Check One		uscitation (DNR/ no CPR) (Allow Natural Death)				
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and					
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.					
2	B Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by a route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.					
Check One	- Total de la					
Box Only	cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.					
	Transfer to hospital if indicated. Avoid intensive care.					
	☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical					
	ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.					
	Other Instructions:					
Section C	ANTIBIOTICS - Treatment for new medical conditions:					
Check One	□ No Antibiotics					
Box Only	☐ Antibiotics Other Instructions:	777777777777777777777777777777777777777				
le-man	REDICALLY ADMINISTED DE LUCO DAUGUITAL O LO					
Section D	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fifeasible.	uids & nutrition must be offered if medically				
Check One	No IV fluids (provide other measures to assure comfort)	☐ No feeding tube				
Box Only in Each	☐ IV fluids for a defined trial period	Feeding tube for a defined trial period				
<u>Column</u>	Ufluids long-term if indicated Other Instructions:	☐ Feeding tube long-term				

STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS

CHAPTER 1200-08-10

(Rule 1200-08-10-.15 continued)

	_					
Section	Discuss	ed with:	The Basis for These Ord	lers is: (Must be con	npleted)	
E	☐ Patier	<u>nt/Resident</u>	☐ Patient's preferences			
	☐ Health	n care agent	Patient's best interest (patient lacks capacity	or preferences unknown)	
	☐ Court-	appointed guardian	☐ Medical indications			
B. de contract	☐ Health	r care surrogate	☐ (Other)			
Must be Completed	☐ Paren	t of minor				
Dompielea	☐ Other	(Specify)				
Physician N	ame	Physician Signature	l	Date	Physician Phone Number	
(Print)	GIFIC	r riyordian orginature	e (Ivialidato(y)	Date	Physician Phone Number	
1777			*			
	Signature	of Patient, Parent of Mir	nor, or Guardian/Health Ca	are Representative		
the second of the second secon	Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Freferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any					
time if your p	references	change, if you are unable t	to make your own health car	e decisions, the order	s should reflect your	
preferences a	is best und	erstood by your surrogate.				
Name (print)	***************************************	<u>Signature</u>		Relationship (write	'self' if patient)	
		0.110				
<u>Surrogate</u>		Relationship	***************************************	Phone Number		
Health Care Pr		Preparer Title		Phone Number	Date Prepared '	
Preparing Forn	0	•				
			900.0			

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

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.

<u>Using POST</u>

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.

(2) Advance Care Plan Form

ADVANCE GARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.
l,, hereby give these advance instructions on how I want to be treated by r dectors 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:
Name:Phone #:Relation:
Address:
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint a alternate:
Name:Phone #:Relation:
Address;
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize leved ones or cannot have a clear conversation with them.
 Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where exygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "ne" means I DO NOT want the treatment.
Yes No 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 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 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 Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Other instructions, such as burial arrangements, hospice care, etc.:

(Rule 1200-08-1015 continued)
(Attach additional pages if necessary)
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
,
Any organ/tissue
SIGNATURE
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.
Signature:DATE:
(Patient)
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.
This document may be notarized instead of witnessed:
STATE OF TENNESSEE COUNTY OF
Lam 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.
My commission expires:
Signature of Notary Public
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
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

ADVANCE CARE PLAN (Tennessee)

	(Telliessee)
treated by m decisions my	, hereby give these advance instructions on how I want to be ny doctors and other health care providers when I can no longer make those treatment self.
Agent: I war decision I cou	t the following person to make health care decisions for me. This includes any health care all have made for myself if able, except that my agent must follow my instructions below:
Name: Relation: Address:	Phone #:
I appoint as a	ent: If the person named above is unable or unwilling to make health care decisions for me, lternate the following person to make health care decisions for me. This includes any health I could have made for myself if able, except that my agent must follow my instructions
Name:	Phone #: Relation:
Address:	
My agent is a	also my personal representative for purposes of federal and state privacy laws, including
<u>time, even if</u>	ve (mark one): □ I give my agent permission to make health care decisions for me at any I have capacity to make decisions for myself. □ I do not give such permission (this form then I no longer have capacity).
adequate com would not be	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given ifort care and pain management. By marking "no" below, I have indicated conditions I willing to live with (that to me would create an unacceptable quality of life).
□ □ Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not
Yes No	recognize loved ones or cannot have a clear conversation with them.
☐ ☐ Yes No	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	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.

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.

Yes No has stopped. Usually this involves □ □ Life Support / Other Artificial Support / Other Artifi	cation): To make the heart beat again and restore breathing after it electric shock, chest compressions, and breathing assistance. Sport: Continuous use of breathing machine, IV fluids, medications, lungs, heart, kidneys, and other organs to continue to work. Is e of surgery, blood transfusions, or antibiotics that will deal with a main illness. Sees to deliver food and water to a patient's stomach or use of IV de artificially delivered nutrition and hydration.
Please sign on page 2	Page 1 of 2
Other instructions, such as burial arrangements	s, hospice care, etc.:
(Attach additional pages if necessary)	
Organ donation: Upon my death, I wish to make the	ha fallowing anatomical sitt (mark and).
☐ Any organ/tissue ☐ My entire body	☐ Only the following organs/tissues:
☐ No organ/tissue donation.	
Your signature must either be witnessed by two	NATURE competent adults or notarized. If witnessed, neither agent or alternate, and at least one of the witnesses must any part of your estate.
Signature:	Date:
Witnesses; (Patient)	
1. I am a competent adult who is not named as the alternate. I witnessed the patient's signature on the signature of the patient's signature.	
2. I am a competent adult who is not named as the alternate. I am not related to the patient to marriage, or adoption and I would not be entitled portion of the patient's estate upon his or her deany existing will or codicil or by operation witnessed the patient's signature on this form.	e agent or blood, and to any Signature of witness number 2 ath under
This document may be notarized instead of witnesse	<u>ed:</u>
STATE OF TENNESSEE COUNTY OF	

STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS

CHAPTER 1200-08-10

(Rule 1200-08-10-.15 continued)

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.

My commission expires:	,
The state of the s	
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS

CHAPTER 1200-08-10

(Rule 1200-08-10-.15 continued)

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.

My commission expires:	
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

- 1. Staff duties;
- 2. Equipment failures;
- 3. Evacuation procedures; and
- 4. Emergency food service.
- (f) Earthquake Disaster Procedures Plan:
 - 1. Staff duties;
 - 2. Evacuation procedures;
 - 3. Safety procedures; and
 - 4. Emergency services.
- (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.
- (3) For facilities which elect to have an emergency generator, the generator shall be designed to meet the facility's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with local resources.
 - (a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.
 - (b) The emergency generator shall be operated at the existing connected load and not on dual power, and a monthly log shall be maintained by the facility. The facility shall have trained staff familiar with the generator's operation.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed July 27, 2000; effective October 10, 2000.

1200-08-11-.14 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

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. CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

I Commence of the commence of	To The Transport	<i>/</i>				
	☐ Resuscitate (CPR)	***************************************	— □ Đo Not	Attempt Re	esuscitate (DNR/no CPR)	
Check One Bex Only	When not in cardiopulm	onary arrest, follow			, ,	
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.					
Check One Box Only	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.					
	Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.					
	☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.					
	Other Instructions:_					
Section C	ANTIBIOTICS Treatme	ent for new medical	conditions:			
Check One Box Only	⊟-Antibiotics					
	Other Instructions:					
Section D	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.					
Check One	☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube					
Box Only in Each Column	☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term					
	Other Instructions:					
Section	Discussed with:		The Basis for Thes	e Ordere la	s: (Must be completed)	
	Patient/Resident Health care agent	,,	Patient's prefer	nterest (palid	ent lacke espacity or preferences unknown)	
Must be Completed	Gourt-appointed guar Health care surrogate		☐ Medical-indicat	ions		
	Parent of minor		(Giher)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Other:Physician Name (Print)	(Specify)	Physician Phone N	lumber	Office Use Only	
	Physician Signature (Mar	ndatory)	Date			
COPY	OF FORM SHALL AC	COMPANY PATI	EMIWHENIRAN	!SFERRIE	D OR DISCHARGED	
	Selection of a service of the servic				FAIRS AND SECURITY	
Significant thou	tient, Parent of Minor, or G ght has been given to life s	ustaining treatmen	Preferences have	been expre	essed to a physician and/or	
nealth-care prof	essional(s). This documer	it-reflects those trea	ilment preferences.			
(If signed by sur Signature	rogate, preferences expre	ssed must reflect p: Vame (print)	allent's wishes as be	st underste Relations	hip (write "self" if patient)	
		·	: :			
Contact Infor	mation	Relationship		nu	li mah m	
~andgare		radialiUHSHID		Phone N	uniosi	

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
Directions POST	I ctions for Health Care Professionals	<u> </u>	

- 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 surregate of a person without capacity, can request
- -alternative treatment.

Reviewing POST

- -This POST should be reviewed if:
- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF TH	IS FORM SHALL ACCOMPANY PATIEN	T WHEN TRANSFERRED OR DISCHARGED	
Physician Ord	ers for Scope of Treatment (POST)	Patient's Last Name	

wishes of to completed in	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, the	n contact physician.	Date of Birth	•		
Section A Check One Box Only		CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing. Resuscitate (CPR) 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	Con route man sus! Limi card vent Tran	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ☐ Transfer to hospital if indicated. Avoid intensive care. ☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.				
		structions;				
Section C Check One Box Only	ANTIBIOTICS - Treatment for new medical conditions: No Antibiotics 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. ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:					
Section E Must be Completed	☐ Health ☐ Court- ☐ Health	nt/Resident n care agent appointed guardian n care surrogate t of minor	The Basis for These Ord ☐ Patient's preferences ☐ Patient's best interest (☐ Medical indications ☐ (Other)		mpleted) y or preferences unknown)	
Physician Na (Print)	ame	Physician Signature	(Mandatory)	Date	Physician Phone Number	
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Preferences have been expressed to a physician and/or health care professional. This form 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	, sann	Relationship (write	"self" if patient)	
Surrogate		Relationship		Phone Number		
Health Care Professional Preparer Title Preparing Form			1			

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

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or notarized.
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:
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:
Name:Phone #:Relation;
Address:
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
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.
Dependent in all Activities of Daily Living: I am по longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
End Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.
Yes No 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 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 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 Tube feeding/IV fluids: Use of tubés to deliver food and water to patient's stemach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Other Instructions, such as burial arrangements, hospice care, etc.:

(Rule 1200-08-1114, continued)
(Attach additional pages if necessary)
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:
SIGNATURE
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witnesses the person you appointed as your agent, and at least one of the witnesses should be someone who is not to you or entitled to any part of your estate.
Signature:DATE:
(Patient)
Witnesses:
1, I am a competent adult who is not named as the agent.
witnessed the patient's signature on this form. Signature of witness number 1
2. am a competent adult who is not named as the agent.
am not related to the patient by blood, marriage, or Signature of witness number 2 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.
This document may be notarized instead of witnessed:
STATE OF TENNESSEE COUNTY OF
Lam 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 a "patient". The patient personally appeared before me and signed above or acknowledged the signature above or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no dure fraud, or undue influence.
My commission expires:
Signature of Notary Public
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
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.
(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)

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.

	CPR (Cardiopulmonary Resuscitation): To	make the heart beat again and restore breathing after i
Yes No	has stopped. Usually this involves electric sho	ck, chest compressions, and breathing assistance.
Yes No	Life Support / Other Artificial Support: Conf	inuous use of breathing machine, IV fluids, medications
	Transment of New Conditions: Lies of annual	t, kidneys, and other organs to continue to work.
Yes No	new condition but will not help the main illness.	y, blood transfusions, or antibiotics that will deal with a
	Tube feeding/W fluids: Use of tubes to delive	a found must be set at the set of
Yes No	fluids into a vein, which would include artificially	er food and water to a patient's stomach or use of IV
	Trade into a Your, which would include althicially	delivered fidifition and nydration.
Please sign o	n page 2	Page 1 of 2
Other instruct	tions, such as burial arrangements, hospice c	are. etc.:
	A commence of the commence of	
5 K 1 6 5 2 2 3 4 1		
(Attach addition	nal pages if necessary)	
Organ donation	on: Upon my death, I wish to make the following	anatomical gift (mark one):
	•	
☐ Any organ/ti	ssue My entire body Or	nly the following organs/tissues:
☐ No organ/tis	sue donation	
LI IVO OIGAII/IIS	sue donation.	•
	SIGNATURE	
Your signature	must either be witnessed by two competent	adulta ar potavinad it vita
witness may be	e the person you appointed as your agent or alter	inate, and at least one of the witnesses, neither
be someone wh	no is not related to you or entitled to any part of y	our estate
Signature:		Data
olgitature.	(Patient)	Date:
Witnesses:	(railein)	
	etent adult who is not named as the agent or	
alternate, I w	vitnessed the patient's signature on this form.	Signature of witness number 1
2. I am a comp	etent adult who is not named as the agent or	
<u>alternate.</u>	am not related to the patient by blood,	
<u>marriage, or</u>	adoption and I would not be entitled to any	Signature of witness number 2
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	e patient's signature on this form.	
mong t e		
<u>i his document</u>	may be notarized instead of witnessed:	
STATE OF TEN		

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.

My commission expires:	
**************************************	Cianatura of Matan, Dublin
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

- 6. The residential hospice shall develop and periodically review with all employees a pre-arranged plan for the orderly evacuation of all patients and/or residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the facility. Fire drills shall be held at least quarterly for each work shift for residential hospice personnel in each separate patient/resident-occupied residential hospice building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.
- (b) Emergency Planning with Local Government Authorities.
 - All residential hospices shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
 - 2. Each residential hospice must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.
 - 3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. Administrative History: Original rule filed August 18, 1995; effective November 1, 1995. Amendment filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed April 27, 2000; effective July 11, 2000. Amendment filed November 22, 2005; effective February 5, 2006.

1200-08-15-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

COPY	DE FORM-SHALL ACCOMPANY PAT	TENT WHEN TRANSFERRED OR DISCHARGED			
£	Physician Orders	Patient's Last Name			
	r Scope of Treatment (POST)				
This is a Phys	iclan Order Sheet based on the medical	First Name/Middle Initial			
conditions and	I wishes of the person-identified at right				
treatment for t	ny section not completed indicates full hat section. When need occurs, first follow	Date of Birth			
these orders, !	then contact physician.				
Section	GARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.			
-A	Resuscitate (CPR)	— ☐ Do Not Attempt Resuscitate (DNR/no CPR)			
Check One	· · ·				
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.				
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.				
	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. — Use medication by any route, positioning, wound care and other measures to relieve pain and suffering.				
011-0	Use oxygen, suction and manual treatment of sirway obstruction as needed for comfort. Do not transfer				
Check One Box Only	to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.				
(1) (4) (4) (5) (5)	Limited Additional Interventions Include	es care described above. Use medical treatment, IV fluids and			

	cardiac menitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.						
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hespital if indicated. Include intensive care.					tiens-mechanical lude-intensive care.	
	Other Instructions:						
Section	ANTIBIOTICS - Treatment for new medical conditions:						
	☐ Ne-Antibiotics						
Check One Box Only	☐ Antibiotics						
Control of the contro	Other Instructions:						
Section D	MEDICALLY ADMINISTE medically feasible.	RED FLUIDS AN	D NUTRITION. Oral	fluids and	nutrition m	ust be offered if	
Check One	No IV fluids (provide c	ther measures to	assure comfort)	-No feeding	J lube		
Box Only in Each	☐ IV fluids for a defined ☐ IV fluids long term if ir	trial period——— idicated———		Feeding to	i be for a d ibe long to	lefined trial period erm	
Column	— Other Instructions:						
Section E	Discussed with:		The Basis for Ther	se Orders I	s: (Must b	e-completed)	
	Health-care agent	**	Patient's prefe		interest (patient lacks capacity or preferences unknown)		
Must be Completed	☐ Court-appointed guare ☐ Health care surrogate	H an	☐ Medical indications ☐				
	Parent of minor		(Other)				
	Other: Physician Name (Print)	(Specify)	Physician Phone N	lumber T	Office Us	se Only	
5 (212) (32)	Physician-Signature (Manu	· ·					
		**					
COP	Y-OF-FORM SHALL ACC	SOMBANA BYL	IENT-WHEN TRA	MSFERRI	D OR D	ISCHARGED	
				a balan ayan da Abbah Ke	i griden der gerande gener		
Significant thou	ti ent, Parent of Minor, or Gu ght has been given to life su	ıstaining treatmen	t. Preferences have	been expr	esed to a	physician and/or	
nealth care prot	essional(s). This document	reflects those tre	atment preferences.				
(If signed by sur Signature	rogale, preferences expres A	sed must reflect p ame (print)	atient's wishes as be	st underste	od by sur	rogate.) *self" if patient)	
		,		1 10/4/10/10	mp (witto-	- oon n panonn	
Contact Infor	mation						
Surrogate		Relationship		Phone Number			
Health Care D	rofessional Preparing	Proporar Til		Phone 1	i i sano in m	[D-4- D	
Form		Preparer Title		- Hone h	(UIIIOSI	Date Prepared	
Directions for Health Care Professionals							
Completing POS	<u>} </u>						
-Must be comp Indications.	leted by a health care profe	ssional based on	patient preferences,	palient bes	t-Interest,	and medical	
POST must be	signed by a physician to bo	e valld. Verbal-ord	ders are acceptable.	with follows	yp signatu	ire by physician in	
accordance w	ith facility/community policy	7				/ p., / e. e. e. e. e.	

- Photocopies/faxes of signed POST forms are legal and valid.
<u>Using POST</u>
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 surregate of a person without capacity, can request —alternative treatment.
Reviewing POST
- This POST should be reviewed if:
(1) The patient is transferred from one care setting or care level to another, or (2) There is a substantial change in the patient's health status, or (3) The patient's treatment preferences change.
Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED						
P	Physician Orders for Scope of Treatment (POST)	Patient's Last Name				
wishes of the completed inc	nysician Order Sheet based on the medical conditions and ne person identified at right ("patient"). Any section not dicates full treatment for that section. When need occurs, first orders, then contact physician.	First Name/Middle Initial Date of Birth				
Section	CARDIOPHI MONARY RESUSCITATION (CPR): Patient ha	e no nulse and/or in not broothing				
A	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.					
Check One						
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and	<u>D.</u>				

Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of alrway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ☐ Transfer to hospital if indicated. Avoid intensive care.					
	vent Other Ins	ilation, and cardioversion a	as indicated. Transfer to h	ion, advanced airw ospital if indicated.	ay interventions mechanical Include intensive care.	
Section C Check One Box Only	□ No A		structions:			
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible. □ No IV fluids (provide other measures to assure comfort) □ No feeding tube □ IV fluids for a defined trial period □ Feeding tube for a defined trial period □ IV fluids long-term if indicated □ Feeding tube long-term Other Instructions:					
Section E Must be Completed	☐ Health☐ Court-☐ Health	nt/Resident n care agent appointed guardian n care surrogate t of minor	The Basis for These Ord ☐ Patient's preferences ☐ Patient's best interest (☐ Medical indications ☐ (Other)	1111	npleted) y or preferences unknown)	
Physician Na (Print)	ime	Physician Signature	(Mandatory)	Date	Physician Phone Number	
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Preferences have been expressed to a physician and/or health care professional. This form 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)		<u>Signature</u>		Relationship (write	"self" if patient)	
Surrogate		Relationship		Phone Number		
Preparer Title Phone Number Date Prepared Prepa						

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

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.

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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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

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

Agent: I want the following	owing person to make health care	e-decisions for me;	
Name:	Phone #:	Relation:	_
Address:			
Alternate Agent: If the alternate:	e person named above is unable	or unwilling to make health care de	cisions for me, I appoint as
Name:	Phone #:	Relation:	=
Address:			
Quality of Life:			a series de la constante de la
I want my doctors to hife that is unacceptable items as you want);	nelp me maintain an acceptable quile to me means when I have any	uality of life including adequate pair of the following conditions (you can	n management. A quality of check as many of these
Permanent L	<u>Inconscious Condition:</u> I become s with little chance of ever waking	totally unaware of people or up from the coma.	
Permanent C	Confusion: I become unable to red do not recognize loved ones or co	member, understand or make annot have a clear conversation with	1 them.
- er move by n	n all Activities of Dally Living: I an nyself. I depend on others for fee n or any other restorative treatme	ding, bathing, dressing and walking	,
full treatment treatment; ch	 Examples: Widespread cancer 	s reached its final stages in spite of r that does not respond anymore to lungs, where exygen needed most- eling of suffocation.	
Treatment:			
If my quality of life bed that medically appropr "no" means I DO NOT	riate treatment be provided as fell	ry condition is irreversible (that is, it lows. Checking "yes" means I WAN	will not improve), I direct T the treatment. Checking
Yes No	CPR (Cardiopulmonary Resuscibreathing after it has stopped. compressions, and breathing a	<u>sitation):</u> To make the heart beat ag Usually this involves electric shock, esistance.	ain and restore chest
Yes No	Life Support/Other Artificial Sup	port: Centinuous use of breathing quipment that helps the lungs, hear	machine, IV t, kidneys and
Yes No		Use of surgery, blood transfusions,	or antibiotics that
Yes No	Tube feeding/IV fluids: Use of t	lubes to deliver food and water to ponich would include artificially deliver	ationt's stomach ed nutrition and
Other instructions, suc	th as burial arrangements, hospic	e care, etc.:	70.000
(Attach additional page	as if necessary)		
		ske the following anatomical aift /nla	anno made anole

(Rule 1200-08-1515, continued) Any organ/tissue	by the following except (6)
	ly the following organs/tissues:
SIGNATU	<u>JRE</u>
Your signature should either be witnessed by two competent be the person you appointed as your agent, and at least one to you or entitled to any part of your estate.	adults or notarized. If witnessed, neither witness should of the witnesses should be someone who is not related
Signature:	DATE;
(Patient)	
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 town a communicate adult when is not a resident the second	
2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or	Signature of witness number 2
- adoption and I would not be entitled to any portion of	· ·
the patient's estate upon his or her death under any existing	g
will or codicil or by operation of law. I witnessed the patient's signature on this form.	
This document may be notarized instead of witnessed:	
STATE OF TENNESSEE COUNTY OF	
Lam a Notary Public in and for the State and County named a personally known to me (or proved to me on the basis of satis "patient". The patient personally appeared before me and sign or her own. I declare under penalty of perjury that the patient fraud, or undue influence.	factory evidence) to be the person who signed as the ned above or acknowledged the signature above as his
My-commission expires:	
	Signature of Notary Public
WHAT TO DO WITH THIS ADVANCE DIRECTIVE	
 Provide a copy to your physician(s) 	
 Keep a copy in your personal files where it is access 	
 Tell your closest relatives and friends what is in the d Provide a copy to the person(s) you named as your h 	
Approved by Tennessee Department of Health, Board for Lice Acknowledgement to Project GRACE for inspiring the develop	nsing Health Care Facilities, February 2, 2005
(2) Advance Care Plan Form	
ADVANCE CA (Tenness	WWW.
hereby aiv	e these advance instructions on how I want to be
treated by my doctors and other health care provide decisions myself.	rs when I can no longer make those treatmen

Name:	Phone #:
Relation: Address:	
Altaenata Aa	
appoint as a	ent: If the person named above is unable or unwilling to make health care decisions for me, Iternate 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
<u>pelow:</u>	
Name:	Phone #: Relation:
Address:	
1001633,	
<u>My agent is a</u> HIPAA,	also my personal representative for purposes of federal and state privacy laws, including
IIIE AA.	
Nhen Effecti	ve (mark one): □ I give my agent permission to make health care decisions for me at any
me, even if	have capacity to make decisions for myself. I do not give such permission (this form
pplies only w	hen 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
<u>adequate com</u>	fort care and pain management. By marking "no" below, I have indicated conditions I
<u>adequate com</u>	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given ifort care and pain management. By marking "no" below, I have indicated conditions I willing to live with (that to me would create an unacceptable quality of life).
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adequate com would not be v Yes No Yes No Yes No Yes No Yes No Yes No Freatment: If conditions mainedically appresented to the conditions of the conditions	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma. 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. 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 a other restorative treatment will not help. 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. my quality of life becomes unacceptable to me (as indicated by one or more of the riced "no" above) and my condition is irreversible (that is, it will not improve), I direct that opriate treatment be provided as follows. By marking "yes" below, I have indicated int. By marking "no" below, I have indicated treatment I do not want. CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after

No

<u>Yes</u>

Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV

new condition but will not help the main illness.

(Rule 1200-08-15-.15, continued) No I fluids into a vein, which would include artificially delivered nutrition and hydration. Please sign on page 2 Page 1 of 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/tissue 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: Date: (Patient) Witnesses: 1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. I am not related to the patient by blood, Signature of witness number 2 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. 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. My commission expires:

Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

12, 1998. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed January 3, 2006; effective March 19, 2006. Amendment filed February 7, 2007; effective April 23, 2007.

1200-08-24-.13 DISASTER PREPAREDNESS.

- (1) Physical Facility and Community Emergency Plans.
 - (a) Every birthing center shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills.
 - (b) The plan(s) must include provisions for the relocation of persons within the building and/or either partial or full building evacuation. Plans that provide for the relocation of patients to other healthcare facilities must have written agreements for emergency transfers. Their agreements may be mutual, i.e., providing for transfer either way.
 - (c) Copies of the plan(s), either complete or outlines, shall be available to all staff. Provisions that have security implications may be omitted from the outline versions. Familiarization information shall be included in employee orientation sessions and more detailed instructions must be included in continuing education programs. Records of orientation and education programs must be maintained for at least three (3) years.
 - (d) Drills of the fire safety plan shall be conducted at least once a year on each major work shift, for a minimum of three times a year for each facility. A combined drill of the other internal emergency plans shall be conducted at least once a year. The risk focus may vary by drill. Both types of drills are for the purposes of educating staff, resource determination, testing personal safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.
 - (e) As soon as possible, real situations that result in a response by local authorities must be documented. This includes a critique of the activation of the plan. Actual documented situations that provided educational and training value may be substituted for a drill.
- (2) Emergency Planning with Local Government Authorities.
 - (a) All birthing centers shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
 - (b) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed March 31, 1998; effective June 12, 1998.

1200-08-24-.14 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

COPY-OF-FORM-SHALL ACCOMPANY-PATIENT-WHEN TRANSFERRED OR DISCHARGED

t			
	foi	Physician Orders r Scope of Treatment (POST)	Patient's Last Name
	conditions and	ician Order Sheet based on the medical wishes of the person identified at right y section not completed indicates full	First Name/Middle Initial
	treatment for the	hat section. When need occurs, <u>first</u> follow <u>hen</u> contact physician.	Date of Birth
	Section A	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.
	Check One	☐ Resuscitate (CPR)	Do Not Attempt Resuscitate (DNR/no CPR)
	Bex Only	When not in cardiopulmonary arrest, follow	orders in B, C, and D.
	Section B	MEDICAL INTERVENTIONS. Patient has p	oulse and/ <u>or</u> is breathing.
	Check One Box Only	Use oxygen, suction and manual treat to hospital for life-sustaining treatment. Limited Additional Interventions Include	ng, wound care and other measures to relieve pain and suffering, ment of alrway obstruction as needed for comfort. Do not transfer. Transfer only if comfort needs cannot be met in current location.
		cardiac monitoring as Indicated. Do no ventilation. Transfer to hospital if Indic	ot use intubation, advanced alrway interventions, or mechanical ated. Avoid intensive care.
		Full Treatment. Includes care above. I ventilation, and cardioversion as indica	Use intubation, advanced airway interventions mechanical ted. Transfer to hospital if indicated. Include intensive care.
I		Other Instructions:	
	Section C	ANTIBIOTICS - Treatment for new medical	conditions:
١		☐ Ne-Antibiotics	
	Check One Box Only	☐ Antibiotics	
		- Other Instructions:	
	Saction D	MEDICALLY ADMINISTERED FLUIDS AND medically feasible.	NUTRITION. Oral fluids and nutrition must be offered if
STICKS INCOME THE PROPERTY OF	Check One Box Only in Each Column	- Other instructions	Feeding tube for a defined trial period
ACCIONATION OF	Section E	Discussed with: Patient/Resident	The Basis for These Orders Is: (Must be completed) Patient's preferences
Continue to the second control of the second	Must be Completed	☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor	Patient's best interest (patient lacks capacity or preferences unknown) Medical indications (Other)
SAMPLEANING		Other: (Specify)	
A 092000186		Physician-Name (Print)	Physician Phone Number Office Use Only
WW295962		Physician Signature (Mandatory)	Date
State of the state	COE	Y OF FORM SHALL ACCOMPANY PATI	ENT WHEN TRANSFERRED OR DISCHARGED
			,
12.23.		RANTS DISSONS IN A STREET OF Guardian/Health Car	Pantesantalius
	Significant thou	ght has been given to life sustaining treatmen essional(s). This document reflects those tre	L. Preferences have been expressed to a physician and/or
	neam care prof	oppromotios. I this appainant tallacte (4:088 (18)	zunantproistances.

(If signed by surrogate, preferences exp Signature	Nam	e (print)	ts Wishes as De	Relationship (write	rrogate.) "self" if patient)
Controlles					
Contact Information Surrogate	T	Dalationakia		Let ii	
annogata		Relationship		Phone Number	
Health Care Professional Preparing Form		Preparer Title		Phone Number	Date Prepared
	Direct	ions for Health Care	- Professionals		
Gempleting POST					
Must be completed by a health care prindications.	ofessk	onal based on palle	nt-preferences,	patient best interest,	and medical
 POST must be signed by a physician to accordance with facility/community po 	e be v licy.	alid. Verbal orders	are acceptable	with follow-up signat	ure by physician in
Photocopies/faxes of signed POST for	ms are	legal and valid.			
Using POST					
Any incomplete section of POST implie	es full-l	ireatment for that so	sction.		
—No defibrillator (including AEDs) should —Attempt Resuscitation*.	d be us	sed on a person wh	o has chosen "E) o No t	
- Oral fluids and nutrition must always be	e <u>offer</u>	<u>ed if medically feas</u> i	ble.		
 When comfort cannot be achieved in the with "Comfort Measures Only", should incomfort (e.g., treatment of a hip fracture. 	be trar	ent setting, the pen referred to a setting	son, including so able to provide	omeone	
- IV-medication to enhance comfort may - "Comfort Measures Only".	be ap	propriate for a pers	e n who has cho	sen	
Treatment of dehydration is a measure should indicate "Limited Interventions" of	which or Ful	prolongs life. A pe l-Trealment-	reo n who de sire	s IV fluids	
—A person with capacity, or the surrogate—alternative treatment.	e of a _f	person without capa	i city, can reque	64	
Reviewing POST					
This POST should be reviewed if:					
(1)—The patient is transferred from one (2)—There is a substantial change in th (3)—The patient's treatment preference	re patie	ent's health status.	l to another, or or		
Draw line through sections A through E	and w	rrite "VOID" in large	letters if POST	is-replaced or becon	nes invalid.
Approved by Tennessee Department of I	lealth,	Board for Licensing	ı Health Care F	acilities, February 2,	2005
COPY OF FORM SHALL ACCO	MPA	NY PATIENT V	HEN TRAN	SFERRED OR C	ISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

 	A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WH	EN TRANSFERRED OR DISCHARGED
	Physician Orders for Scope of Treatment (POST)	Patient's Last Name
wishes of to completed in	hysician Order Sheet based on the medical conditions an the person identified at right ("patient"). Any section no identified at right ("patient"). Any section no identified at right ("patient"). When need occurs, first orders, then contact physician.	<u>f First Name/Middle Initial</u>
Tiow triese	orders, then contact physician.	Date of Birth
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient I	as no pulse and/or is not breathing.
<u>A</u> Check One		suscitation (DNR/ no CPR) (Allow Natural Death)
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, a	
<u>Section</u> <u>B</u>	MEDICAL INTERVENTIONS. Patient has pulse and/or is Comfort Measures. Treat with dignity and respect. Ke route, positioning, wound care and other measures to remanual treatment of airway obstruction as needed for consustaining treatment. Transfer only if comfort needs	ep clean, warm, and dry. Use medication by any lieve pain and suffering. Use oxygen, suction and imfort. Do not transfer to hospital for life-
Check One Box Only	☐ Limited Additional Interventions. Includes care desc cardiac monitoring as indicated. Do not use intubati ventilation. Transfer to hospital if indicated. Avoid intensive care	on, advanced airway interventions, or mechanical
	☐ Full Treatment. Includes care above. Use intub- ventilation, and cardioversion as indicated. Transfer to	ation, advanced airway interventions mechanical hospital if indicated. Include intensive care.
	Other Instructions:	
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions: No Antibiotics Antibiotics Other Instructions:	
Section	MEDICALLY ADMINISTERED FLUIDS & NUTRITION, Ora	fluids & nutrition must be offered if medically
<u>D</u> Check One	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Ora feasible. No IV fluids (provide other measures to assure comfort)	
<u>D</u>	teasible. ☐ No IV fluids (provide other measures to assure comfort) ☐ IV fluids for a defined trial period	☐ No feeding tube ☐ Feeding tube for a defined trial period
<u>D</u> Check One Box Only in	teasible. ☐ No IV fluids (provide other measures to assure comfort)	☐ No feeding tube
Check One Box Only in Each	teasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident Health care agent The Basis for These Or Patient's preferences Patient's best interest	☐ No feeding tube ☐ Feeding tube for a defined trial period
Check One Box Only in Each Column Section	teasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident The Basis for These Or	□ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term ders is: (Must be completed)
D Check One Box Only in Each Column Section E Must be Completed Physician Na	teasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident Health care agent Court-appointed guardian Health care surrogate Parent of minor Other: (Specify)	□ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term ders is: (Must be completed)
Check One Box Only in Each Column Section E Must be Completed Physician Na (Print)	No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other instructions: Discussed with: Patient/Resident Health care agent Court-appointed guardian Health care surrogate Parent of minor Other: (Specify) The Basis for These Or Patient's preferences Patient's best interest Medical indications (Other) Other: (Specify) Physician Signature (Mandatory)	□ No feeding tube □ Feeding tube for a defined trial period □ Feeding tube long-term ders Is: (Must be completed) (patient lacks capacity or preferences unknown) Date Physician Phone Number
Check One Box Only in Each Column Section E Must be Completed Physician Na (Print) Preferences hat me if your pr	teasible. No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period IV fluids long-term if indicated Other Instructions: Discussed with: Patient/Resident Health care agent Court-appointed guardian Health care surrogate Parent of minor Other: (Specify)	No feeding tube Feeding tube for a defined trial period Feeding tube long-term ders Is: (Must be completed) (patient lacks capacity or preferences unknown) Date Physician Phone Number Care Representative

\$urrogate	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

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".

<u>Treatment of dehydration is a measure which prolongs life.</u> 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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or
I,, hereby give these advance instructions on how I want to be treated by my dectors 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:
Name:Phone #:Relation:
Address:
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint a alternate:
Name:Phone #: Relation:
Address:
Quality of Life:
I want my dectors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
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,
Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
End Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.
Yes No 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 Life Support/Other Artificial Support: Continuous use of breathing machine, IV Iluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that
Yes No will deal with a new condition but will not help the main illness.

Yes No or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Other instructions, such as burial arrangements, hospice care, etc.:
(Attach additional pages if necessary)
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
Any organ/tissue My entire body Only the following organs/tissues:
SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.
Signature: DATE:
(Patient)
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.
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.
My commission expires:
Signature of Notary Public
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

December, 2009 (Revised)

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)

I. treated by my decisions mys	, hereby give these advance instructions on how I want to be doctors and other health care providers when I can no longer make those treatment self.
Agent: I want decision I cou	t the following person to make health care decisions for me. This includes any health care ld have made for myself if able, except that my agent must follow my instructions below:
Name: Relation: Address:	Phone #:
i appoint as al	ent: If the person named above is unable or unwilling to make health care decisions for me, ternate the following person to make health care decisions for me. This includes any health I could have made for myself if able, except that my agent must follow my instructions
Name:	Phone #: Relation:
Address:	
When Effective	re (mark one): I give my agent permission to make health care decisions for me at any
applies only w	have capacity to make decisions for myself. I do not give such permission (this form hen I no longer have capacity).
adequate com	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given fort care and pain management. By marking "no" below, I have indicated conditions I would be live with (that to me would create an unacceptable quality of life).
☐ ☐ Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ ☐ Yes No	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	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	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.

<u>Treatment:</u> 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.

Yes No	CPR (Cardiopulmonary Resuscitation): To	make the heart beat again and restore breathing after it
169 140	has stopped. Usually this involves electric sho	ck, chest compressions, and breathing assistance.
	Life Support / Other Artificial Support: Con	tinuous use of breathing machine, IV fluids, medications,
<u>Yes No</u>	and other equipment that helps the lungs, hear	t, kidneys, and other organs to continue to work.
	Treatment of New Conditions: Use of surge	ry, blood transfusions, or antibiotics that will deal with a
<u>Yes No</u>	new condition but will not help the main illness.	
	Tube feeding/IV fluids: Use of tubes to delive	er food and water to a patient's stomach or use of IV
Yes No	fluids into a vein, which would include artificially	delivered nutrition and hydration.
Please sign or		Page 1 of 2
Otner Instructi	<u>ons, such as burial arrangements, hospice c</u>	are, etc.:

(Attach addition	al pages if necessary)	
1	<u>x. pages it 11000004; </u>	
Organ donatio	n: Upon my death, I wish to make the following	anatomical diff (mark one):
☐ Any organ/tis	sue ☐ My entire body ☐ ○	nly the following organs/tissues:
	The state of the s	

☐ No organ/tiss	ue donation.	
	SIGNATURE	
Variation of	and the second second	
Your signature i	niist either he Witnescad hu hua campatant ad:	
may be the bei	con you oppointed as your seed as the seed	ults or notarized. If witnessed, neither witness
compone who is	son you appointed as your agent or alternate	and at least one of the witnesses must be
someone who is	son you appointed as your agent or alternate not related to you or entitled to any part of your	and at least one of the witnesses must be
someone who is	son you appointed as your agent or alternate	and at least one of the witnesses must be
someone who is Signature:	son you appointed as your agent or alternate	and at least one of the witnesses must be estate.
someone who is	son you appointed as your agent or alternate	and at least one of the witnesses must be
someone who is	son you appointed as your agent or alternate not related to you or entitled to any part of your	and at least one of the witnesses must be estate.
Signature: Witnesses:	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient)	and at least one of the witnesses must be estate.
Signature: Witnesses:	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or	and at least one of the witnesses must be estate. Date:
Signature: Witnesses:	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient)	and at least one of the witnesses must be estate.
Signature: Witnesses: 1. I am a compalternate. I w	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form.	and at least one of the witnesses must be estate. Date:
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compa	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form.	and at least one of the witnesses must be estate. Date:
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood.	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or	son you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any	and at least one of the witnesses must be estate. Date:
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the	con you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing	(Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing	con you appointed as your agent or alternate not related to you or entitled to any part of your (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing witnessed the	(Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or itnessed the patient's signature on this form. etent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing witnessed the	(Patient) etent adult who is not named as the agent or attented to the patient's signature on this form. etent adult who is not named as the agent or attent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I patient's signature on this form.	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing witnessed the This document r	(Patient) etent adult who is not named as the agent or attented to the patient's signature on this form. etent adult who is not named as the agent or attent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I patient's signature on this form.	and at least one of the witnesses must be estate. Date: Signature of witness number 1
Signature: Witnesses: 1. I am a compalternate. I w 2. I am a compalternate. I marriage, or portion of the any existing witnessed the	(Patient) etent adult who is not named as the agent or attented to the patient's signature on this form. etent adult who is not named as the agent or attent adult who is not named as the agent or am not related to the patient by blood, adoption and I would not be entitled to any patient's estate upon his or her death under will or codicil or by operation of law. I patient's signature on this form.	and at least one of the witnesses must be estate. Date: Signature of witness number 1

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.

My commission expires:	
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

1200-08-25-.17 APPENDIX.

(1) Physician Orders for Scope of Treatment (POST) Model Form

COPY OF	FORM-SHALL-ACCOMPANY PATIE	ENT WHEN TRANSFERRED OR DISCHARGED		
Physician Orders		Patient's Last Name		
for	Scope of Treatment (POST)			
	•	First Name/Middle Initial		
This is a Ph	ysician Order Sheet based on the	FIISCHVAIHE/WILGUIE MIIIIAI		
	nditions and wishes of the person			
Identified at	right ("patient"). Any section not	Date of Birth		
completed I	ndicates full treatment for that	İ		
	hen need occurs, <u>first</u> follow these n contact physician.			
Section	CARDIOPULMONARY RESUSCITATION /	CPR): Patient has no pulse <u>and/or</u> is not breathing.		
A	OUTDIOLOTHOUNTH HEGOGOTHAHOM	orn). Patient has no pulse <u>anglor</u> is not preathing.		
AL	☐—Resuscitate (CPR)————————————————————————————————————	□ <u>□</u> e <u>Not Attempt Resuscitate (DNR/ne CPR)</u>		
Check One Box Only	When not in cardiopulmenary arrest, follow	orders in D. C. and D.		
Section B	MEDICAL INTERVENTIONS. Palient has p	oulse and/or is breathing.		
	⊟-Comfort Measures Treat with dignity ar	d respect. Keep clean warm and day		
	 Use medication by any route, positioning 	3. Wound care and other measures to relieve pain and		
Check-One	Suffering. Use oxygen, suction and man	Wal-treatment of airway obstruction as needed for comfort.		
Box Only	in current location.	ning treatment. Transfer <u>only</u> if comfort needs cannot be met		
0.00000000	риллен			
6.000,000	Limited Additional Interventions Include	s care described above. Use medical treatment, IV fluids		
Action and the con-	mechanical ventilation. Transfer to hose	not use intubation, advanced airway interventions, or		
	mechanical ventilation. Transfer to hospital if Indicated. Avoid intensive care.			
0.0000000000000000000000000000000000000	Full Treatment. Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to be a likely to the control of			
	ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.			
	instructions			
Section C	ANTIBIOTICS - Treatment for new medical	conditione:		
	□ No Antibiotics			
Check-One	☐ Antibiotics	İ		
Box Only	Other			
	Instructions:			
Section	BACTICALLY AMBILITATION TO THE SING ALSO	NUTRITION. Oral fluids and nutrition must be offered if		
D D	medically feasible.	PNU HALLON. Oral fluids and nutrition must be offered if		
	•			
Gheck One Box-Only-in	No IV fluids (provide other measures to a little for a defined trial period			
Each	Ell 14 hard for a dominos that poster	Feeding tube for a defined trial		
Golumn	☐ IV-fluids long-term If indicated	Feeding tube long-term		
	Other			
List Care de l'Octobre	Instructions:			
Section E	Discussed with:	The Basis for These Orders Is: (Must be completed)		
		Patient's preferences Patient's best interest (patient lacks capacity or preferences		
Must be	Court-appointed guardian	unknown)		

Completed	Health care surrogate Parent of minor		☐ Me ☐ (Other	edical Indicat	ions		
	Other: (Specify) Physician Name (Print)		Physician Phone Number		Office Use Only		
	Physician Signature (Mandatory)		Date				
CObx	OF FORM SHALL ACCO	МРАНУ РАЦЕ	MIMI	ENTRANS	FERREI) OK DIS	CHARGED
Signature of Pa	lient, Parent of Minor, or Gu	ardien/Health Car	e-Ropre	sentative			
health care prof	ght has been given to life su essional(s). This document	staining treatmen reflects those tre	t. Prefe atment p	rences have references.	been exp	ressed to a	physician and/or
(if signed by sur	rrogate, preferences express	sed must reflect p	atient's \	wishes as be	st underst	lood by sur	rogale.)
Orginatore	121	am e (p rint)			Kelation	ship (write	"self" if patient)
Contact In	fermation						
Surrogate		Relationship	•		Phone-	Number	
Health Care P	rofessional Preparing	Preparer Titl	8		Phone	Number	Date Prepared
Form					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		and the property
		ections for Health	Care Pi	ofessionals		•••	
Completing POS	manalay,						
- Must be comp indications.	oleted by a health care profe	ssional based on	patient _i	oreferences,	patient be	ist interest,	and medical
POST must b accordance w	e signed by a physician to b ith facility/community policy.	e-valid. Verbal or	ders are	-acceptable-	with follow	v-up-eignat	ure by physician in
- Photocopies/fa	exes of signed POST forms	are legal and valid	1.				
Using POST							
Any incomplete	e section of POST implies fo	II treatment for th	at sectio	n.			
—No defibrillator —Attempt Resus	(including AEDs) should be citation.	used on a persor	n who he	is-chosen "D	e-Net		
—Oral fluids and	nutrition must always be off	ered_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 t "Comfort Meas	—IV medication to enhance comfort may be appropriate for a person who has chosen —"Comfort Measures Only".						
—Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids —should indicate "Limited Interventions" or "Full Treatment".							
— A person with capacity, or the surrogate of a person without capacity, can request —alternative treatment.							
Reviewing POST							
This POST should be reviewed if:							
(1) The patient is transferred from one care setting or care level to another, or (2) There is a substantial change in the patient's health status, or							

(3) The patient's treatment preferences change.

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

A	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	N TRANSFERRED OR DISCHARGED	
	Physician Orders for Scope of Treatment (POST)	Patient's Last Name	
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		First Name/Middle Initial	
follow these o	orders, then contact physician.	Date of Birth	
Section A Check One	CARDIOPULMONARY RESUSCITATION (CPR): Patient has Resuscitate (CPR)	is no pulse and/or is not breathing. suscitation (DNR/ no CPR) (Allow Natural Death)	
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and	<u>D.</u>	
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is br Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to reliemanual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs c	o clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and efort. Do not transfer to hospital for life-	
Check One Box Only			
	Full Treatment. Includes care above. Use intubation ventilation, and cardioversion as indicated. Transfer to ho	on, advanced alrway interventions mechanical aspital if indicated. Include intensive care.	
Section Section	ANTIBIOTICS - Treatment for new medical conditions:		
Check One Box Only	No Antibiotics Other Instructions:		
Section D	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluid feasible.	uids & nutrition must be offered if medically	
Check One Box Only in Each	 No IV fluids (provide other measures to assure comfort) IV fluids for a defined trial period 	☐ No feeding tube ☐ Feeding tube for a defined trial period	
Column	☐ IV fluids long-term if indicated Other Instructions:	☐ Feeding tube long-term	

Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: (Specify)		☐ Medical indications ☐ (Other)		mpleted) y or preferences unknown)
(Print)	Physician Name Physician Signature (Print)			Date	Physician Phone Number
Freferences hat t me if your pr	iave been ex references (xpressed to a physician and	nor, or Guardian/Health Condon indexing the second index professional to make your own health cares.	This form can be rev	iewed and updated at any s should reflect your
Name (print)	(print) Signature		Relationship (write "self" if patient)		"self" if patient)
Surrogate		Relationship		Phone Number	
Health Care Pro Preparing Form		Preparer Title		Phone Number	Date Prepared

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

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.

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This POST should be reviewed if:

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- (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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.
I,, hereby give these advance instructions on how I want to be treated by dectors 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:
Name:Phone#:Relation:
Address:
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint alternate:
Name:Phone#:Relation:
Address:
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
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.
Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
End Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is Irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking means I DO NOT want the treatment.
Yes No 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 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.
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 Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Other instructions, such as hurial arrangements, hospica care, etc.

(Nule 1200-06-2517, continued)
(Attach additional pages if necessary)
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:
SIGNATURE
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness s be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to any part of your estate.
Signature: Date;
(Patient)
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.
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 preved to me on the basis of satisfactory evidence) to be the person who signed as t "patient". The patient personally appeared before me and signed above or acknowledged the signature above at 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
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
Approved by Tennessee Department of Health, Beard for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.
(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)

l. , 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).
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
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.
Pependent 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 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.

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.

		CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after i
Yes	No.	has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	 No ∶	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.
		Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a
Yes	No	new condition but will not help the main illness.
		Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV
Yes	<u>No</u>	fluids into a vein, which would include artificially delivered nutrition and hydration.
Please	sign or	page 2 Page 1 of 2
Other in	nstruct	ons, such as burial arrangements, hospice care, etc.:
(Attach	addition	al pages if necessary)
<u>Organ c</u>	<u>ionatio</u>	n: Upon my death, I wish to make the following anatomical gift (mark one):
☐ Any o	organ/tis	ssue
		City the following organishessues.
	rgan/tis	sue donation,
		SIGNATURE
Your sig	ınature	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed neither
Your sic	nature may be	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must
Your sic	nature may be	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed neither
Your sig witness be some	nature may be one wh	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must
Your sic	nature may be one wh	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date:
Your signification witness be some	nature may be cone wh	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate.
Your significant your signatur Witnesse	nnature may be eone wh e:	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient)
Your sigwitness be some Signatur Witnesse 1. I am a	nature may be eone wh e: es:	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient)
Your sigwitness be some Signatur Witnesse 1. I am a	nature may be eone wh e: es:	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient)
Your significant witness of the some Signatur Witness of the some 1. I am a alternation 2. I am a	nature may be cone wh e: es: a compe ate. I w	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. Signature of witness number 1
Your sic witness be some Signatur Witnesse 1. I am a alterna 2. I am a alterna	nature may be eone wh e: es: a compe ate. I w	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) etent adult who is not named as the agent or itnessed the patient's signature on this form. Signature of witness number 1 etent adult who is not named as the agent or am not related to the patient by blood,
Your significant witness is be some Signatur Witnesse 1. I am a alterna alterna marria	nature may be cone wh e: es: a compe ate. I w i compe ate. I	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2
Your significant witness is be some Signatur Witnesse 1. I am a alterna marria portior	nature may be cone wh e: as: a compe ate. I w compe ate. I	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must or is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2
Your significance of the some	e: a competed ate. I was competed ate. I was competed ate. I age, or a control of the existing	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2 Signature of witness number 2
Your significance witness Signatur Witnesse 1. I am a alterna marria portior any e witness	e: a compete le compete le	Signature must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2 Signature of witness number 2
Your sice witness be some Signatur Witnesse 1. I am a alterna marria portior any e witness This doctors	e: a compete la compe	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2 Signature of witness number 2
Your significance witness Signatur Witnesse 1. I am a alterna marria portior any e witness	e: a compete le compe	SIGNATURE must either be witnessed by two competent adults or notarized. If witnessed, neither the person you appointed as your agent or alternate, and at least one of the witnesses must o is not related to you or entitled to any part of your estate. Date: (Patient) Signature of witness number 1 Signature of witness number 1 Signature of witness number 2 Signature of witness number 2 Signature of witness number 2

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.

My commission expires:	40.000 A. C.
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. Administrative History: Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.

1200-08-26-.14 DISASTER PREPAREDNESS.

- (1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
- (2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209. **Administrative History:** Original rule filed May 31, 2000; effective August 14, 2000.

1200-08-26-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

COPYO	F-FORM SHALL ACCOMPANY-PATI	ENT WHEN TRANSFERRED OR DISCHARGED	
fe	Physician Orders r Scope of Treatment (POST)	Patient's Last Name	
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.		First Name/Middle-Initial Date of Birth	
Section -A	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.	
Check One	Resuscitate (CPR)	Do Not Attempt Resuscitate (DNR/no CPR)	
Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.		
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.		
Check-One Bex Only	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 fer life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.		
	Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.		
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.		
	Other Instructions:		
Section C	ANTIBIOTICS - Treatment for new medical of	onditions:	
	☐ No Antiblotics		
Check One Box Only	☐ Antibletics		
	— Other Instructions:		
Section D	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.		

(Rule 1200-08-26-.15, continued) Check One ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube IV fluids for a defined trial period Box Only in Feeding tube for a defined trial period Each IV fluids long-term if Indicated Feeding tube long-term Column Other Instructions: Section Discussed with: The Basis for These Orders Is: (Must be completed) ☐ Patient/Resident Patient's preferences Health-care agent Patient's best-interest (patient lacks capacity or preferences unknown) -Court-appointed guardian Must be Medical Indications Completed Health care surrogate Parent of minor (Other) Other: (Specify) Physician Name (Print) Physician Phone Number Office Use Only Physician Signature (Mandatory) Date COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. (If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.) Signature Name (print) Relationship (write "self" if patient) Contact Information Surregate Relationship Phone-Number Health Care Professional Preparing Preparer Tille Phone Number Date Prepared Form 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 "Gomfort Measures Only",

CHAPTER 1200-08-26

(Rule 1200-08-26-.15, continued)

—Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids —should indicate "Limited Interventions" or "Full Treatment".
—A person with capacity, or the surrogate of a person without capacity, can request —alternative treatment.
Reviewing POST
- This POST should be reviewed if:
(1) The patient is transferred from one care setting or care level to another, or (2) There is a substantial change in the patient's health status, or (3) The patient's treatment preferences change.
Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

Į.	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	TRANSFERRED OR DISCHARGED	
1	Physician Orders for Scope of Treatment (POST)	Patient's Last Name	
This is a P	hysician Order Sheet based on the medical conditions and		
wishes of t	he person identified at right ("patient"). Any section not	First Name/Middle Initial	
dompleted in	dicates full treatment for that section. When need occurs, first		
follow these	orders, then contact physician.	Date of Birth	
<u> </u>			
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient ha	s no pulse and/or is not breathing.	
Lhook One	1	uscitation (DNR/ no CPR) (Allow Natural Death)	
Check One Box Only	C TOTAL CONTROL		
Section	MEDICAL INTERVENTIONS Patient has nulse and/or is he	roothing	
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is be Comfort Measures. Treat with dignity and respect. Keep	reathing. o clean, warm, and dry. Use medication by any	
	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie	oclean, warm, and dry. Use medication by any ove pain and suffering. Use oxygen, suction and	
	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for com	o clean, warm, and dry. Use medication by any ove pain and suffering. Use oxygen, suction and ofort. Do not transfer to hospital for life-	
	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie	o clean, warm, and dry. Use medication by any ove pain and suffering. Use oxygen, suction and ofort. Do not transfer to hospital for life-	
В	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and affort. Do not transfer to hospital for lifecannot be met in current location.	
	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of Limited Additional Interventions. Includes care descrit	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and effort. Do not transfer to hospital for lifecannot be met in current location.	
B Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of the Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation.	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and afort. Do not transfer to hospital for lifecannot be met in current location.	
B Check One	☐ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and afort. Do not transfer to hospital for lifecannot be met in current location.	
B Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of the Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care.	o clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and afort. Do not transfer to hospital for lifecannot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical	
B Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid Intensive care. □ Full Treatment. Includes care above. Use intubation	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and afort. Do not transfer to hospital for lifecannot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical	
B Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs of the Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care.	o clean, warm, and dry. Use medication by any ever pain and suffering. Use oxygen, suction and afort. Do not transfer to hospital for lifecannot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical	

CHAPTER 1200-08-26

(Rule 1200-08-26-.15, continued)

Section	ANTIBIOTICS – Treatment for new medical conditions:				
<u>C</u> Check One Box Only	□ No /	Antibiotics	structions:		
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible. ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:				
Section E Must be Completed	Discussed with: □ Patient/Resident □ Health care agent □ Court-appointed guardian □ Health care surrogate □ Parent of minor □ Other: (Specify) The Basis for These Orders Is: (Must be on the patient's preferences) □ Patient's preferences □ Patient's best interest (patient lacks capa of the patient's preferences) □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's preferences □ Patient's best interest (patient lacks capa of the patient's preferences □ Patient's preferences □ Patient's best interest (patient lacks capa of the patient's preferences □ Patient's preferences □ Patient's best interest (patient lacks capa of the patient's preferences				
Physician Na (Print)		Physician Signature		<u>Date</u>	Physician Phone Number
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Preferences have been expressed to a physician and/or health care professional. This form can be reviewed and updated at any me 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 Preparer Title Freparing Form		:	Phone Number	Date Prepared	

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

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".

<u>Treatment of dehydration is a measure which prolongs life.</u> 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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

(Rule 1200-08-2615, c		· ve these advance instructions on how I want to be treated by	
doctors and other health c	are providers when I can no	ve these advance instructions on how I want to be treated by o longer make those treatment decisions myself.	, 1113
Agent: I want the following	j person to make health ca i	re decisions for me;	
Name;	Phone #:	Relation:	
Address:			
Alternate Agent: If the per alternate:	son named above is unable	e or unwilling to make health care decisions for me, I appoin	t as
Name:	Phone#:	Relation:	
Address:			
Quality of Life:			
I want my dectors to help r life that is unacceptable to items as you want):	ne maintain an acceptable o me means when I have an	quality of life including adequate pain management. A quali y of the following conditions (you can check as many of thes	ity of se
Permanent Uncor	nscious Condition: I becom little chance of ever waking	e totally unaware of people or g up from the coma.	
Permanent Confu decisions. I do no	<u>sion: I become unable to re</u> v t recegnize loved ones or c	emember, understand or make cannet have a clear conversation with them.	
or move by mysel	Activities of Daily Living: I a f. I depend on others for fe any other restorative treatme	am no longer able to talk clearly seding, bathing, dressing and walking. ent will not help.	
full treatment. Exi-	amples: Widespread cance	as reached its final stages in spite of er that dees not respond anymore to d lungs, where oxygen needed most of eeling of suffecation.	
Treatment:			
If my quality of life becomes that medically appropriate t "no" means I DO NOT wan	realment be provided as fo	my condition is irreversible (that is, it will not improve), I directillows. Checking "yes" means I WANT the treatment. Check	st ki ng
Yes No bre	R (Cardiopulmonary Resus athing after it has stopped. apressions, and breathing o	seltation): To make the heart beat again and restore Usually this involves electric shock, chest assistance.	
Yes No fluid	Support/Other Artificial Su	equipment that helps the lungs, heart, kidneys and	
I I I I I I I I I I I I I I I I I I I	atment of New Conditions:	Use of surgery, blood transfusions, or antibiotics that out will not help the main illness.	
Yes No Tub	<u>e feeding/IV fluids: Use of</u>	tubes to deliver food and water to patient's stomach which would include artificially delivered nutrition and	
Other instructions, such as	burial arrangements, hospi	ce care, etc.;	
(Attach additional pages if r			

CHAPTER 1200-08-26

(Rule 1200-08-26-.15, continued) Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one): SIGNATURE Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate. Signature: 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 Signature of witness number 2 - 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. This document may be notarized instead of witnessed: STATE OF TENNESSEE COUNTY OF Lam 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. My-commission expires: Signature of Notary Public 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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Tennessee)

CHAPTER 1200-08-26

(Rule 1200-08	8-2615, continued)	
treated by m	, hereby give these advance instructions on how I want to be ny doctors and other health care providers when I can no longer make those treatment	
decisions mys	self.	
Agent: I wan	at the following person to make health care decipions for me. This includes any health area	
decision I cou	nt the following person to make health care decisions for me. This includes any health care all have made for myself if able, except that my agent must follow my instructions below:	
	A STATE OF THE GOOD OF CHARLETTY AGENCY THOSE TOHOW THY WISH ACTIONS DELOW.	
Name:	Phone #:	
Relation:		
Address:		
Altarrata A.		
Lappoint as a	ent: If the person named above is unable or unwilling to make health care decisions for me.	
care decision	Ilternate the following person to make health care decisions for me. This includes any health I could have made for myself if able, except that my agent must follow my instructions	
below:	Todale have made for myself it able, except that my agent must rollow my instructions	
Name:	Phone #: Relation:	
Address:		
My agent is a	also my personal representative for purposes of federal and state privacy laws, including	
HIPAA.	allo my personal representative for purposes of federal and state privacy laws, including	
When Effective	ve (mark one): ☐ I give my agent permission to make health care decisions for me at any	
<u>time, even if I</u>	I have capacity to make decisions for myself. D I do not give such permission (this form	
<u>applies only w</u>	vhen I no longer have capacity).	
Quality of Life	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given	
agequate com	nfort care and pain management. By marking "no" below, I have indicated conditions I	
MODIO HOLDE A	willing to live with (that to me would create an unacceptable quality of life).	
	Permanent Unconscious Condition: I become totally unaware of people or surroundings with litt	1
Yes No	chance of ever waking up from the coma.	<u>.e</u>
	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not	
Yes No	recognize loved ones or cannot have a clear conversation with them.	
	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or	
Yes No	move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or a	2021
	other restorative treatment will not help.	IIIĀ
	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment.	
Yes No	Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged hear	+
	and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of	2
	suffocation.	

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.

	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it
<u>Yes No</u>	has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

CHAPTER 1200-08-26

	3-2615, continued)		
Yes No	- 1		
Western The Party of the Party	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal w		
Yes No	new condition but will not help the main illness.		
Yes No	fluide into a rain which would in the desired	er food and water to a patient's stomach or use of IV	
169 140	fluids into a vein, which would include artificially	delivered nutrition and hydration.	
Please sign o	n page 2	Page 1 of 2	
Other instruct	tions, such as burial arrangements, hospice c	are, etc.:	
harry was a second seco			
(Attach addition	nal pages if necessary)		
Organ donatio	on: Upon my death, I wish to make the following	anatomical gift (mark one):	
☐ Any organ/tis	ssue ☐ My entire body ☐ Or	the 4th of full problems are supplied to	
LI //// Olgan/ti	D wy entile body D Oi	nly the following organs/tissues:	

☐ No organ/tis	sue donation.		
=			
witness may be	SIGNATURE must either be witnessed by two competent to the person you appointed as your agent or alter tho is not related to you or entitled to any part of y	nate, and at least one of the witnesses must	
Signature:		Date:	
	(Patient)	E G C C C C	
Witnesses:			
1 lamacomo	etent adult who is not named as the agent or		
alternate I w	vitnessed the patient's signature on this form.	Cionalina of vila	
373717460, 241	randoced and patients signature on this torn.	Signature of witness number 1	
2. I am a comp	etent adult who is not named as the agent or		
<u>alternate. I</u>	am not related to the patient by blood,		
	adoption and I would not be entitled to any	Signature of witness number 2	
	patient's estate upon his or her death under		
	will or codicil or by operation of law. I e patient's signature on this form.		
Millegged file	5 patient 5 signature on tins torrit.		
This document	may be notarized instead of witnessed:		
OTATE OF TE	INFOORE		
STATE OF TEN	4INE SOEE		
COUNTY OF		MATTER AND AND AND AND AND AND AND AND AND AND	
I am a Notarv P	ublic in and for the State and County named abo	IVP. The nerson who claned this instrument	
		ind position and algred and material	

is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who

CHAPTER 1200-08-26

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.

My commission expires:	
	Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

1200-08-27-.14 DISASTER PREPAREDNESS.

- (1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
- (2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209. **Administrative History:** Original rule filed April 17, 2000; effective July 1, 2000.

1200-08-27-.15 APPENDIX !

(1) Physician Orders for Scope of Treatment (POST) Form

COPY C	PE FORM SHALL ACCOMPANY PAT	HENT WHEN TRANSFERRED OR DISCHARGED			
	Dhysisian Orders	Patient's Last Name			
Physician Orders for Scope of Treatment (POST)		Fallont o East Ivallie			
10	r 300pe di 118aunem (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		First Name/Middle Initial Date of Birth			
these orders, t	hen contact physician.				
Section	, •				
A A	A.	GPR): Patient has no pulse and/or is not breathing.			
Check One	☐ Resuscitate (CPR)	— ☐ <u>Do Not Attempt Resuscitate (DNR/no CPR)</u>			
Box Only	When not in cardiopulmonary arrest, follow				
Section B	MEDICAL INTERVENTIONS. Patient has a	pulse and/ <u>or</u> is breathing.			
Check One Box Only	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions:				
Section	ANTIBIOTICS - Treatment for new medical conditions:				
C C	THE THE STREET THE SURFICE THE STREET CONDITIONS:				
	☐ No Antibietics				
Check One Bex Only	☐ Antibiotics				
	Other Instructions:				
Section D	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.				
Check One	☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube				

(Rule 1200-08-27-.15, continued) Box Only in ☐ IV fluids for a defined trial period Each - IV fluids long-term if indicated Column Other Instructions:_

Feeding tube for a defined trial period Feeding tube long-term Section Discussed with: The Basis for These Orders Is: (Must be completed) Patient/Resident
Health-care agent
Court-appointed guardian Patient's preferences
Patient's best interest
Medical indications
(Other) E Patient's best interest (patient lacks capacity or preferences unknown) Must be Health care surrogate
Parent of minor Completed Other: (Specify) Physician Name (Print) Physician Phone Number Office Use Only Physician Signature (Mandatory) Date

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative						
Significant thought has been given to life	FGuardia fe sustain	i n/Health Care Represe	ntalive	hasa ayaraasad ta a		
health care professional(s). This docum	nent refle	mg neannem, Freisier ets those treatment prei	ices nave- ferences-	oeen expressea ro a	-physician and/or	
		•				
(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.) Signature Name (print) Relationship (write "self" if nation)						
	Harrio-	(huur)	-	Relationship (write "sell" if patient)		
Contact Information	,					
Surrogate	F	Relationship		Phone Number		
Health Care Professional Preparing	, E	Teparer Title		Phone Number	Deta Danasa	
Form	• -	10paror 11110		FHUNG NUMBER	Date Prepared	
	Directio	ns for Health Care Profe	essionals		L	
Completing POST						
Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.						
POST must be signed by a physician to be valid. Verbal orders are acceptable with follow up signature by physician in accordance with facility/community policy.						
Photocopies/faxes of signed POST forms are legal and valid.						
Using POST						
—Any incomplete section of POST implies full treatment for that section.						
—No defibrillator (including AEDs) should be used on a person who has chosen "Do Not — Attempt Resuscitation".						
—Oral fluids and nutrition must always be offered if medically feasible.						
 When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). 						
- IV medication to enhance comfort may be appropriate for a person who has chosen°Comfort Measures Only°.						
Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids						

- should indicate "Limited Interventions" or "Full Treatment".

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

Reviewing POST

- This POST should be reviewed if:

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

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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

A	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	N TRANSFERRED OR DISCHARGED		
	Physician Orders for Scope of Treatment (POST) hysician Order Sheet based on the medical conditions and	Patient's Last Name		
wishes of the person identified at right ("patient"). Any section not dompleted indicates full treatment for that section. When need occurs, first follow these orders, then contact physician		First Name/Middle Initial Date of Birth		
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient ha			
<u>A</u> Check One Box Only		uscitation (DNR/ no CPR) (Allow Natural Death)		
Section B Check One Box Only	cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical			
	ventilation. Transfer to hospital if indicated. Avoid intensive care. Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions:			
Section C	ANTIBIOTICS – Treatment for new medical conditions:			
Check One Box Only	□ No Antibiotics □ Antibiotics Other Instructions:			

STANDARDS FOR HOMECARE ORGANIZATIONS PROVIDING HOSPICE SERVICES

CHAPTER 1200-08-27

(Rule 1200-08-27-.15, continued)

Section	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically					
<u> </u> <u>D</u>	feasible.	ible.				
<u>Check One</u>	□ No!	lo IV fluids (provide other measures to assure comfort)				
Box Only in		uids for a defined trial pe			be for a defined trial period	
<u>Each</u>		uids long-term if indicate	A CONTRACTOR OF THE CONTRACTOR		pe long-term	
<u>Column</u>		structions:	distribution of the state of th			
Section	Discussi	ed with:	The Basis for These Ord	iare le /Must he cor	nnisted)	
I E		nt/Resident	☐ Patient's preferences	ioro ia. (irradi de cor	intered)	
		n care agent		(nationt lacks canacity	y or preferences unknown)	
	F=-7	appointed guardian	☐ Medical indications	pattern launa capacit	(or breferences auvirowit)	
		n care surrogate	(Other)			
<u>Must be</u>		t of minor	<u> </u>			
<u>Completed</u>	☐ Other:					
Physician Na	<u>ıme</u>	Physician Signature	e (Mandatory)	Date	Physician Phone Number	
			a timosadato. Fr	5410		
(Print)			o (massage)	<u></u>	7 9 4 1 7 1 7 1 7 1 7 1 7 1 7 1 7 1 7 1 7 1	
		of Patient, Parent of Mir	nor, or Guardian/Health Ca	are Representative		
Freferences h	ave been e	of Patient, Parent of Mir	nor, or Guardian/Health Ca	are Representative	lewed and undated at any	
Freferences had me if your pr	ave been e) references	of Patient, Parent of Mir kpressed to a physician and change. If you are unable t	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative	lewed and undated at any	
references he t me if your pr preferences a	ave been e) references	of Patient, Parent of Mir kpressed to a physician and change. If you are unable t erstood by your surrogate.	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative This form can be rev e decisions, the order	lewed and updated at any s should reflect your	
Freferences hat me If your pr	ave been e) references	of Patient, Parent of Mir kpressed to a physician and change. If you are unable t	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative	lewed and updated at any s should reflect your	
Preferences had me if your proferences as hame (print)	ave been e) references	of Patient, Parent of Mir spressed to a physician and change. If you are unable t erstood by your surrogate. Signature	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative This form can be reveled the order Relationship (write	lewed and updated at any s should reflect your	
Preferences had me if your proferences as	ave been e) references	of Patient, Parent of Mir kpressed to a physician and change. If you are unable t erstood by your surrogate.	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative This form can be rev e decisions, the order	lewed and updated at any s should reflect your	
Preferences hat me if your preferences as Name (print)	ave been e) eferences s best und	of Patient, Parent of Mir kpressed to a physician and change. If you are unable t erstood by your surrogate. Signature Relationship	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative This form can be reveled the order Relationship (write	lewed and updated at any s should reflect your	
Preferences had me if your proferences as hame (print)	ave been e) references s best unde	of Patient, Parent of Mir spressed to a physician and change. If you are unable t erstood by your surrogate. Signature	nor, or Guardian/Health Ca d/or health care professional. to make your own health car	are Representative This form can be reveled the order Relationship (write	lewed and updated at any s should reflect your	

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

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.

<u>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.</u>

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

(Rule 1200-08-27-.15, continued) Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized. , 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; Name: Phone #: Relation: Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate: Phone #: Relation: Name: Address:— Quality of Life: I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want); Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma. 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. Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help. End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation. Treatment: If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment. CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore Yes -No breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance. Life Support/Other Artificial Support: Continuous use of breathing machine, IV Yes No. fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work. \Box Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that Yes No will deal with a new condition but will not help the main illness. Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach Yes -No or use of IV fluids into a vein which would include artificially delivered nutrition and hydration,

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

(Rule 1200-08-2715, continued)
(Attach additional pages if necessary)
Organ denation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:
SIGNATURE
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness shou be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.
Signature:DATE:
Signature: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.
This document may be notarized instead of witnessed:
STATE OF TENNESSEE COUNTY OF
Lam 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.
My commission expires:
Signature of Notary Public
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
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

December, 2009 (Revised)

(2) Advance Care Plan Form

ADVANCE CARE PLAN (Tennessee)

<u></u>	, hereby give these advance instructions on how I want to be
decisions my	y doctors and other health care providers when I can no longer make those treatment
acoisions my	<u>5611.</u>
Agent: I wan	t the following person to make health care decisions for me. This includes any health care
decision I cou	ald have made for myself if able, except that my agent must follow my instructions below:
Name: Relation:	Phone #:
Address:	
	·
Alternate Age	ent: If the person named above is unable or unwilling to make health care decisions for me,
care decision	Iternate the following person to make health care decisions for me. This includes any health
below:	I could have made for myself if able, except that my agent must follow my instructions
name and the second	
Name:	Phone #: Relation:
Addraga	
Address:	
My agent is a	also my personal representative for purposes of federal and state privacy laws, including
HIPAA.	private interest
isthma rassauti	
time even if	ve (mark one): I give my agent permission to make health care decisions for me at any
applies only w	I have capacity to make decisions for myself. □ I do not give such permission (this form then I no longer have capacity).
	The foliage flove depastey.
<u> </u>	
Quality of Life	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given
adequate com	fort care and pain management. By marking "no" below. I have indicated conditions I
would not be v	willing to live with (that to me would create an unacceptable quality of life).
Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little
	chance of ever waking up from the coma. Permanent Confusion: I become unable to remember, understand, or make decisions. I do not
Yes No	recognize loved ones or cannot have a clear conversation with them.
	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or
<u>Yes No</u>	rnove by myseir. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any
F-1 2*****	other restorative treatment will not help.
Yes No	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment.
169 140	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.
	1 management of the second of

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.

Yes No has stopped. Usually this involves electric sha	make the heart beat again and restore breathing after it			
- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
The service of the se				
The state of the s				
Yes No Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with new condition but will not help the main illness.				
),			
Yes No fluids into a vein, which would include artificial	er food and water to a patient's stomach or use of IV			
Tee 140 hads into a vent, which would include artificial	iy delivered nutrition and nydration.			
Please sign on page 2	Page 1 of 2			
Other instructions, such as burial arrangements, hospice	care ofc			
- William - Will	CULT OF OTTO 1			
	Management of the second of th			
/Attack additional and a				
(Attach additional pages if necessary)				
Organ donation: Upon my death, I wish to make the following	anatomical gift (mark one):			
	Samuel and the same and the sam			
☐ Any organ/tissue ☐ My entire body ☐ C	only the following organs/tissues:			
A CONTRACTOR OF THE CONTRACTOR				
☐ No organ/tissue donation.				
SIGNATURE				
Your cignature must although a witnessed by the company	A matriffe b 1 1 to the 10 to 10			
Your signature must either be witnessed by two competen	t adults or notarized. It witnessed, neither			
witness may be the person you appointed as your agent or alte be someone who is not related to you or entitled to any part of	Male, and at least one of the withesses must			
po de mono uno lo nocholated to you or entitled to any part of	your estate.			
Signature:	Date;			
(Patient)				
Witnesses:				
4 Lans a named and adult when to make a make a				
1. I am a competent adult who is not named as the agent or				
alternate. 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 as				
2. I am a competent adult who is not named as the agent or alternate. I am not related to the patient by blood,				
marriage, or adoption and I would not be entitled to any	Signature of witness number 2			
portion of the patient's estate upon his or her death under	T. G. G. WILLIOUS HARRIST Z			
any existing will or codicil or by operation of law.				
witnessed the natient's signature on this form				
witnessed the patient's signature on this form.				
witnessed the patient's signature on this form. This document may be notarized instead of witnessed:				

STANDARDS FOR HOMECARE ORGANIZATIONS PROVIDING HOSPICE SERVICES

CHAPTER 1200-08-27

(Rule 1200-08-2715, continued)	
STATE OF TENNESSEE	
COUNTY OF	
I am a Notary Public in and for the State and County named above.	The person who signed this instrumen
is personally known to me (or proved to me on the basis of satisfa	ctory evidence) to be the nerson who
signed as the "patient." The patient personally appeared before me a	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:	
	A CONTRACTOR OF THE PROPERTY O
Sig	nature of Notary Public
,	

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

- (III) Fighting the fire
- (IV) Evacuation procedures
- (V) Staff functions by department and job assignment
- (VI) Fire drill schedules (fire drills shall be held at least quarterly on each work shift)
- (ii) External disaster procedures plan (for tornado, flood, earthquakes) shall include:
 - (I) Staff duties by department and job assignment
 - (II) Evacuation procedures
- (iii) Bomb Threat Procedures Plan:
 - (I) Staff duties by department and job assignment
 - (II) Search team, searching the premises
- 6. The HIV supportive living facility shall develop and periodically Review with all employees a pre-arranged plan for the orderly evacuation of all residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the facility. Fire drills shall be held at least quarterly for each work shift for HIV supportive living facility personnel in each separate resident occupied HIV supportive living facility building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.
- (b) Emergency Planning with Local Government Authorities.
 - All HIV supportive living facilities shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
 - Each HIV supportive living facility must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.
 - 3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. **Administrative History:** Original rule filed July 27, 2000; effective October 10, 2000. Amendment filed December 15, 2005; effective February 28, 2006.

1200-08-28-.15 APPENDIX (

_(1) Physician Orders for Scope of Treatment (POST) Form

COPY C	PEFORM SHALL ACCOMPANY PAT	HENT WHEN TRANSFERRED OR DISCHARGED				
fo	Physician Orders or Scope of Treatment (POST)	Patient's Last Name				
conditions and ("patient"). An	ician Order Sheet based on the medical I wishes of the person identified at right ry section not completed indicates full	Firet Name/Middle Initial Date of Birth				
these orders, <u>t</u>	hat section. When need occurs, <u>first</u> follow then contact physician.	,				
Section A		CPR): Patient has no pulse and/or is not breathing.				
Check One	Resuscitate (CPR)	Do Not Attempt Resuscitate (DNR/no CPR)				
Box Only	When not in cardiopulmonary arrest, follow of					
Section B	MEDICAL INTERVENTIONS. Patient has p	•				
Check One Box Only	Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.					
	Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac menitering as indicated. Do not use intubation, advanced alrway interventions, or mechanical ventilation. Transfer to hospital-if indicated. Avoid intensive care.					
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.					
	Other Instructions:					
Section C	ANTIBIOTICS - Treatment for new medical of	conditions:				
	□ Ne Antiblotics					
Check One Box Only	☐ Antibiotics					
	Other Instructions:					
Section D	medically feasible.	NUTRITION. Oral fluids and nutrition must be offered if				
Check One Box Only in	No IV fluids (provide other measures to a IV fluids for a defined trial period	assure comfort) — ☐ No feeding tube ☐ Feeding tube for a defined trial period				
Each Column	☐ IV fluids long-term if indicated ☐ Feeding tube long-term — Other Instructions:					
Section	Discussed with:	The Basis for These Orders Is: (Must be completed)				
	Patient/Resident Health care agent	Patient's preferences Patient's best interest (patient lacks capacity or preferences unknown)				
Must be Completed	Court-appointed guardian Health care surrogate Parent of minor (Other)					
	Other: (Specify) Physician Name (Print)	Physician Phone Number Office Use Only				
	Physician Signature (Mandatory)	Date				
COP	Y OF FORM SHALL ACCOMPANY PATI	ENT WHEN TRANSFERRED OR DISCHARGED				

Signature of Patient, Parent of Minor, or Gue	ardian/Health Care Representative				
Significant thought has been given to life-sur health care professional(s). This document	staining treatment. Preferences have	been expressed to a	t physician and/or		
(If signed by surrogate, preferences express	ed must reflect patient's wishes as b	est understood by su	uonala)		
Signature Na	ame (print)	Relationship (write	-self if patient)		
		,	•		
Contact Information					
Surrogate	Relationship	Phone Number			
Canagaio	Noraliu lariip	PHORS WURNDER			
Health Care Professional Preparing Form	Preparer-Title	Phone Number	Date Prepared		
Dir			<u> </u>		
	sometion to the manufacture of the options of the sound in the sound i				
Completing POST					
Must be completed by a health care profes indications.	sional based on patient preferences,	-patient best interest,	and medical		
—POST must be signed by a physician to be accordance with facility/community policy.	valid. Verbal orders are acceptable	with follow-up signate	ure by physician in		
Photocopies/faxes of signed POST forms a	are legal and valid.				
Using POST					
Any incomplete section of POST implies full-treatment for that section.					
—Ne defibrillater (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 fluide eshould indicate "Limited Interventions" or "Full Treatment".					
 A person with capacity, or the surregate of a person without capacity, can request alternative treatment. 					
Reviewing POST					
This POST should be reviewed if:					
 The patient is transferred from one care setting or care level to another, or There is a substantial change in the patient's health status, or The patient's treatment preferences change. 					
Draw-line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.					
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005					
COPY OF FORM SHALL ACCOME	ANY PATIENT WHEN TRAN	SFERRED OR C	NSCHARGED		

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

	COPY OF THIS FORM	SHALL ACC	COMPANY PATIENT WHEN	TRANSFERRED (OR DISCHARGED
<u> </u>	hysician Orders for Sc	ope of Trea	atment (POST)	Patient's Last Nan	ne
wishes of to completed in	e person identified a	t_right_("pa that section	e medical conditions and tient"). Any section not n. When need occurs, first	First Name/Middle	Initial
Section	CARDIOPULMONAR	Y RESUSCI	TATION (CPR): Patient ha	s no pulse and/or i	s not breathing.
A Check One Box Only		nonary arres	st, follow orders in B, C, and	<u>D.</u>	CPR) (Allow Natural Death)
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for lifesustaining treatment. Transfer only if comfort needs cannot be met in current location.				
Check One Box Only	Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.				
	☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions:				
Section	ANTIBIOTICS - Treati	ment for ne	w medical conditions:		
Check One Box Only	□ No Antibiotics □ Antibiotics Other Instructions:				
Section	MEDICALLY ADMINIS	TERED FL	UIDS & NUTRITION. Oral fi	uids & nutrition mus	t be offered if medically
<u>D</u> Check One	feasible. No IV fluids (provi	de other me	asures to assure comfort)	☐ No feeding	tuha
Box Only in Each	IV fluids for a defi	ned trial pe	riod		be for a defined trial period
<u>Column</u>	☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:				
Section E	Discussed with: The Basis for These Orders Is: (Must be completed) ☐ Patient/Resident ☐ Patient's preferences ☐ Health care agent ☐ Patient's best interest (patient lacks capacity or preferences unknown)				
<u>Must be</u> Completed	☐ Court-appointed guardian ☐ Medical Indications ☐ Health care surrogate ☐ (Other) ☐ Parent of minor ☐ Other: (Specify)				
Physician Na (Print)	ne Physicia	n Signature	(Mandatory)	Date	Physician Phone Number
Preferences hat me if your pr	ve been expressed to a p	hysician and are unable to	or, or Guardian/Health Car lor health care professional. o make your own health care	This form can be rev	lewed and updated at any s should reflect your

Name (print)	Signature	Relationship (write "self" if patient)
<u>\$urrogate</u>	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

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.

<u>Using POST</u>

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Compet their own choosing.	ent adults and emancipated minors may give advance instructions using this form or any form of Fo be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or netarized.	
l,doctors and other hea	hereby give these advance instructions on how I want to be treated alth care providers when I can no longer make those treatment decisions myself.	by my
	owing person to make health care decisions for me:	
Name:	Phone #: Relation:	
Address;		
Alternate Agent: If the alternate:	e person named above is unable or unwilling to make health care decisions for me, I appo	∍int as
Name:	Phone #; Relation;	
Address:		
Quality of Life:		
I want my doctors to hat is unacceptab items as you want):	nelp me maintain an acceptable quality of life including adequate pain management. A quale to me means when I have any of the following conditions (you can check as many of the	ality of lese
Permanent L surroundings	Inconscious Condition: I become totally unaware of people or with little chance of ever waking up from the coma.	
Permanent C	<u>Confusion:</u> I become unable to remember, understand or make do not recognize loved ones or cannot have a clear conversation with them.	
or move by n	n all Activities of Daily Living: I am no longer able to talk clearly nyself. I depend on others for feeding, bathing, dressing and walking, n or any other restorative treatment will not help.	
full treatment treatment; ch	nesses: I have an illness that has reached its final stages in spite of Examples: Widespread cancer that does not respond anymore to pronic and/or damaged heart and lungs, where oxygen needed most of activities are limited due to the feeling of suffocation.	
Treatment:		
If my quality of life bec that medically appropr "no" means I DO NOT	comes unacceptable to me and my condition is irreversible (that is, it will not improve), I divide treatment be provided as follows. Checking "yes" means I WANT the treatment. Chewant the treatment.	r ect ecking
Yes No	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	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	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	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and	

(Rule 1200-08-28-.15, continued) hydration. Other instructions, such as burial arrangements, hospice care, etc.:______ (Attach additional pages if necessary) Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one): SIGNATURE Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate. Signature: ___ DATE: (Patient) 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 Signature of witness number 2 - 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. This document may be notarized instead of witnessed: STATE OF TENNESSEE COUNTY OF _____ Lam 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. My commission expires: Signature of Notary Public 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

Approved by Tennessee Department of Health Board for Licensing Health Core i

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

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).	
Permanent Unconscious Condition: become totally unaware of people or surroundings with little chance of ever waking up from the coma.	_
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 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 an other restorative treatment will not help.	
Yes No No 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.	

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.

Yes No	CPR (Cardiopulmonary Resuscitation): To	make the heart beat again and restore breathing after i
Yes No	has stopped. Usually this involves electric sho	ck, chest compressions, and breathing assistance.
Yes No	and other equipment that helps the lungs has	tinuous use of breathing machine, IV fluids, medications t, kidneys, and other organs to continue to work.
	Treatment of New Conditions: Use of surge	ry, blood transfusions, or antibiotics that will deal with a
Yes No	new condition but will not help the main illness	To blood translations, or antibiotics that will deal with a
	Tube feeding/IV fluids: Use of tubes to delive	er food and water to a patient's stomach or use of IV
Yes No	fluids into a vein, which would include artificiall	y delivered nutrition and hydration.
Please sign o	n page 2	Page 1 of 2
Other instruct	tions, such as burial arrangements, hospice o	care. etc.:
H	The state of the s	Angelia
(Attach addition	nal pages if necessary)	
Organ donation	on: Upon my death, I wish to make the following	anatomical gift (mark one):
☐ Any organ/ti	ssue My entire body O	nly the following organs/tissues:
	The state of the s	my the following organishissues.
V		
☐ No organ/tis	Cup densition	
Li No Organinis	sue donation.	
	SIGNATURE	
Your signature	must either be witnessed by two competent	adults or notarized. If witnessed, neither
he someone w	e the person you appointed as your agent or alte no is not related to you or entitled to any part of y	rnate, and at least one of the witnesses must
DC GOTTICOTIC WI	no is not related to you or entitled to any part or y	<u>our estate.</u>
Signature:		Date:
Witnesses:	(Patient)	
vviiilesses.		
1. I am a comp	etent adult who is not named as the agent or	
	vitnessed the patient's signature on this form.	Signature of witness number 1
0 1	ativity of the second second	***************************************
alternate.	etent adult who is not named as the agent or am not related to the patient by blood,	
	adoption and I would not be entitled to any	Signature of witness number 2
portion of the	patient's estate upon his or her death under	
any existing	will or codicil or by operation of law. I	
	e patient's signature on this form.	
This document	may be neterized instead of with second.	
THO ADDRINGIE	may be notarized instead of witnessed:	•
STATE OF TEN	INESSEE	

(F	₹ule	1200	0-08-28-	.15,	continue	d)
-	~		-			

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.
My commission expires:
Signature of Notary Public

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

- 2. Evacuation procedures;
- 3. Safety procedures; and
- 4. Emergency services.

All facilities shall participate in the Tennessee Emergency Management local/county emergency plan on an annual basis. Participation includes but is not limited to filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation shall be maintained and shall be made available to survey staff as proof of participation.

(2) In the event of natural disaster or electrical power failure, no new dialysis procedures shall be begun, and dialysis procedures in progress shall be brought to conclusion as soon as possible.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed April 22, 2003; effective July 6, 2003.

1200-08-32-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

CODY	OE CODRA CHALL ACCOSADARIN DA	TIPLE AND ICAL TO AN OCCUPANT OF THE STATE O		
. 69:	OF FORWFORALL AGGOMEANT PA	TIENT WHEN TRANSFERRED OR DISCHARGED		
Physician Orders		Patient's Last Name		
10	r Scope of Treatment (POST)			
This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right		First Name/Middle Initial		
("patient"). A n	y section not completed indicates full	Date of Birth		
	hat section. When need occurs, first follow hen contact physician.	Date of Birth		
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or is not breathing.</u>		
and The Control	Resuscitate (CPR)	☐ De Net Attempt Resuscitate (DNR/ne CPR)		
Check One Box Only	When not in cardiopulmonary arrest, follow	•		
Section B	MEDICAL INTERVENTIONS. Patient has p	oulse and/ <u>or is breathing.</u>		
	☐ Comfort Measures Treat with dignity ar	nd respect. Keep clean, warm, and dry.		
Check One	Use medication by any route, positioning Use oxygen, suction and manual treatn	ng, wound care and other measures to relieve pain and suffering. nent of airway obstruction as needed for comfort. Do not transfer to ransfer only if comfort needs cannot be met in current location.		
Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids cardiac monitoring as indicated. Do not use intubation, advanced already interventions, or mechanical monitoring as indicated.				
	ventilation. Transfer to hospital if Indica			
	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	ANTIBIOTICS - Treatment for new medical	conditions:		
	☐ No Antibiotics			
Check One Bex Only	Antiblotics			

	Other Instructions:						
Section D	MEDICALLY ADMINISTER	ED FLUIDS AN	NUTRITION, Oral	fluids and i	nutrition n	nust be offered if me	dic
Check One Box Only in Each Column	No IV fluids (provide of IV fluids for a defined tr	ial period	assure comfort)	—□ No fe □ Feedi □ Feedi		or a defined trial per	od
MATTER CONTEST OF THE							
Section E Must be Completed	Discussed with: Patient/Resident Health care agent Court appointed guardic Health care surrogate Parent of minor Other:	an (Specify)	The Basis for Thei Patient's prefe Patient's best Medical indica (Other)	rences interest (psti	•	De Completed) Pacity or proferences unknown	>\n)
	Physician Name (Print)		Physician Phone N	lumber	Office Us	e-Only	
	Physician Signature (Manda	atory)	Date				
eo.	PY OF FORM SHALL ACC	'OMPANY PA'	TENT WHEN TRA	NSFERR	ED OR I	NSCHARGED	75 75
Signature of Pa Significant thou health care pro	Atient, Parent of Minor, or Gua ight has been given to life suc fessional(s). This document i progate, preferences expressional	taining treatmen reflects those tre	t. Preferences have alment preferences.	est understo	ood by su		
Contact Info	rmotion						
Surrogate	HYMARION	Relationship		Phone N	lumber		2007
Health Care F Form	Professional Preparing	Preparer Title	9	Phone N	umber	Date Prepared	
	Dire	I ctions for Health	Care-Professionals	<u> </u>			-
Completing PO	<u>ST</u>						
- Must be comp indications.	pleted by a health care profesi	sionai based on l	patient preferences,	patient bes	t Interest,	and medical	
POST must b	e signed by a physician to be with facility/community policy.	valid. Verbal-ore	iers are acceptable	with follow	u p s ignatu	ıre by physician in	
Photocopies/f	axes of signed POST forms a	re legal and valle	1.				
Using POST							
-Any incomplet	te section of POST implies ful	l-treatment-for-th	at section.				
- No defibrillato Attempt Resu	r (including AEDs) should be r sollation".	used on a persor	≀who has chosen "C)o Not			
— Oral-fluids and	l nutritlon <u>must</u> always be <u>offe</u>	red_if_medically-l	easible.				
When comfort	cannot be achieved in the cu	rrent setting, the	person, including so	omeone			

-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: The patient is transferred from one care setting or care level to another, or There is a substantial change in the patient's health status, or (3) The patient's treatment preferences change. Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid. Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(1) Physician Orders for Scope of Treatment (POST) Form

	<u> </u>	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	TRANSFERRED OR DISCHARGED			
	Physician Orders for Scope of Treatment (POST) Patient's Last Name					
	This is a Physician Order Sheet based on the medical conditions and vishes of the person identified at right ("patient"). Any section not					
1	ompleted in bliow these o	dicates full treatment for that section. When need occurs, first orders, then contact physician.	Date of Birth			
H			1000			
	Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient has	s no pulse and/or is not breathing.			
	A		****			
	Check One	A STATE OF THE STA	uscitation (DNR/ no CPR) (Allow Natural Death)			
200	Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and	<u>D.</u>			
	Section	MEDICAL INTERVENTIONS. Patient has pulse and/or is he	eathing			
	Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is br	eathing.			
	Section B	Comfort Measures. Treat with dignity and respect. Keep	clean, warm, and dry. Use medication by any			
The analysis whether		Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie	clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and			
The Control of the Co		Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for com	clean, warm, and dry. Use medication by any ve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-			
		Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie	clean, warm, and dry. Use medication by any ve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-			
	B	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of alrway obstruction as needed for com sustaining treatment. Transfer only if comfort needs of	clean, warm, and dry. Use medication by any ve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for lifeannot be met in current location.			
	<u>B</u> Check One	 ☐ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of alrway obstruction as needed for comsustaining treatment. Transfer only if comfort needs c ☐ Limited Additional Interventions. Includes care described. 	clean, warm, and dry. Use medication by any ve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for lifeannot be met in current location.			
	B	Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of alrway obstruction as needed for com sustaining treatment. Transfer only if comfort needs of	clean, warm, and dry. Use medication by any the pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs computed Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation.	clean, warm, and dry. Use medication by any the pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs computed Limited Additional Interventions. Includes care described cardiac monitoring as indicated. Do not use intubation	clean, warm, and dry. Use medication by any ve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for lifeannot be met in current location.			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs consustaining treatment. Transfer only if comfort needs consustaining treatment. Includes care described cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care. □ Full Treatment. Includes care above. Use intubation	clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs consustaining treatment. Transfer only if comfort needs consustaining treatment. Includes care described cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care. □ Full Treatment. Includes care above. Use intubation	clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs consustaining treatment. Transfer only if comfort needs consustaining treatment. Includes care described cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care. □ Full Treatment. Includes care above. Use intubation ventilation, and cardioversion as indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated. Transfer to hospital indicated.	clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical			
	<u>B</u> Check One	□ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for comsustaining treatment. Transfer only if comfort needs consustaining treatment. Transfer only if comfort needs consustaining treatment. Includes care described cardiac monitoring as indicated. Do not use intubation ventilation. Transfer to hospital if indicated. Avoid intensive care. □ Full Treatment. Includes care above. Use intubation	clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-annot be met in current location. Deed above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical on, advanced airway interventions mechanical			

DO NOT ALTER THIS FORM!

STANDARDS FOR END STAGE RENAL DIALYSIS CLINICS

CHAPTER 1200-08-32

(Rule 1200-08-32-.15, continued)

Section	ANTIBIOTICS – Treatment for new medical conditions:						
<u>C</u> Check One Box Only	□ No.						
Section D Check One Box Only in Each Column	teasible. No I I IV fl	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible. No IV fluids (provide other measures to assure comfort) No feeding tube Feeding tube for a defined trial period IV fluids long-term if indicated Other Instructions:					
Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other: ☐ Court-appointed (Specify) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)						
Physician Na (Print)	\$5577 0			e (Mandatory)	Da		Physician Phone Number
Freferences ha t me if your pr	Signature of Patient, Parent of Minor, or Guardian/Health Care Representative Preferences have been expressed to a physician and/or health care professional. This form 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)		<u>Signature</u>			R	elationship (write	"self" if patient)
<u>\$urrogate</u>		Relationship			Р	hone Number	
Health Care Pro Preparing Form		Preparer Title			Р	hone Number	Date Prepared

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

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or

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 follo	owing person to make health car	re decisions for me:	
Name:	Phone#:	Relation;	
Address:			
Alternate Agent: If the alternate:	e person named above is unable	or unwilling to make health car	e decisions for me, I appoint as
Name:	Phone #:	Relation;	·
Address:			
Quality of Life:			
I want my doctors to he of life that is unaccept these items as you wa	nelp me maintain an acceptable (table to me means when I have (ant);	quality of life including adequate any of the following conditions ()	pain management. A quality ou can check as many of
Permanent L surroundings	Inconscious Condition: I becom with little chance of ever waking	e totally unaware of people or 3 up from the coma.	
Permanent C decisions. Le	<u>Confusion: I become unable to redo not recognize loved ones or c</u>	emember, understand or make cannot have a clear conversation	a with them.
or move by n	n all Activities of Daily Living: I a nyself. I depend on others for fe n or any other restorative treatmo	eding, bathing, dressing and wa	lking.
full treatment treatment; ch	nesses: I have an illness that ha Examples: Widespread cance renic and/or damaged heart and activities are limited due to the fo	er that does not respond anymore that does not respond anymore oxygen needed o	a in
Treatment:			
that medically appropr	comes unacceptable to me and r late treatment be provided as fo I DO NOT want the treatment.	ny condition is irreversible (that llows. Checking "yes" means L'	is, it will not improve), I direct WANT the treatment.
Yes No	CPR (Cardiopulmonary Resus breathing after it has stopped- compressions, and breathing a	citation): To make the heart beaution. Usually this involves electric shassistance.	at again and restore lock, chest
Yes No	Life Support/Other Artificial Sufficials, medications, and other other organs to continue to wo	pport: Continuous use of breath equipment that helps the lungs, rk.	heart, kidneys and
Yes No	Treatment of New Conditions: will deal with a new condition be	Use of surgery, blood transfusion will not help the main illness.	ons, or antibiotics that
Yes No	Tube feeding/IV fluids: Use of	tubes to deliver food and water hich would include artificially de	to patient's stomach
Other Instructions, suc	h as burial arrangements, hospi	ce care, etc.;	
(Attach additional page	es if necessary)		
	nal): Upon my death, I wish to m	rake the following anatomical git	t (nlease mark one):
	☐ My entire body [-	

SIGNATUR	DE
Your signature should either be witnessed by two competent as should be the person you appointed as your agent, and at least related to you or entitled to any part of your estate.	
Signature:	570 A 700 600
(Patient)	DATE:
Witnesses:	
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
-	orginature of manese 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	Signature of witness number 2
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.	•
pation o orginatoro or this form.	
This document may be notarized instead of witnessed:	
STATE OF TENNESSEE	
COUNTY OF	
epatient". The patient personally appeared before me and signs or her own. I declare under penalty of perjury that the patient appropriately appeared by the patient of the	ppears to be of sound mind and under no duress,
My commission expires:	Signature of Notary Public
	agnature of rectary Fubilic
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 	e to olbers
 Tell your closest relatives and friends what is in the doc 	
Provide a copy to the person(s) you named as your her	
Approved by Tennessee Department of Health, Board for Licens	sing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the developm	ent of this form.
(2) Advance Care Plan Form	
ADVANCE CARE	E PLAN
(Tennessee	
1.01110000	=
, hereby give t	hese advance instructions on how I want to b
reated by my doctors and other health care providers	When I can no longer make those treatmen
decisions myself.	
Agent: I want the following person to make health care de	cisions for me. This includes any health care

March, 2011 (Revised)

decision I could have made for myself if able, except that my agent must follow my instructions below:

Name:	Phone #:
Relation:	C TOTO IT
Address:	
Alternate Ag	ent: If the person named above is unable or unwilling to make health care decisions for me,
I appoint as a	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:
A -1 -1	
Address:	
My agent is	also my personal representative for purposes of federal and state privacy laws, including
<u>HIPAA.</u>	
When Effect	ive (mark one). It I give my exent norminging to make health care desiring to
time, even if	ive (mark one): □ I give my agent permission to make health care decisions for me at any I have capacity to make decisions for myself. □ I do not give such permission (this form
applies only	vhen I no longer have capacity).
_	
Quality of Li	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given
adequate cor	nfort 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).
	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little
Yes No	chance of ever waking up from the coma.
	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not
<u>Yes No</u>	recognize loved ones or cannot have a clear conversation with them.
<u> </u>	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or
<u>Yes No</u>	move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any
	other restorative treatment will not help.
Yes No	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.

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.

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

Please sign on page 2 Page 1 of 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/tissue donation.			
<u>SIGNATURE</u>			
Your signature must either be witnessed by two competent adults or notarized. If witnessed, neither witnessed 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: Date:			
<u>(Patient)</u> <u>Witnesses:</u>			
1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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.			
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.			
My commission expires:			

Signature of Notary Public	

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

Page 2 of 2

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

1200-08-34-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

€OBA-€	COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED				
[]	Physician Orders	Patient's Last Name			
fo	r-Scope of Treatment (POST)				
	, ,				
This is a Phys	ician Order Sheet based on the medical	First Name/Middle-Initial			
conditions and	wishes of the person identified at right				
("patient"). An	y section not completed indicates full				
	hat section. When need occurs, first follow	Date-of-Birth			
these orders, t	<u>hen</u> contact physician.				
Section	CARDIOPULMONARY RESUSCITATION (CDD): Dollant has as anyles	31 - 1 - 0 1 1 7		
-A	ON COLOR DEMONSTRATE SOSSIMATION (orm, ranem nas no puise <u>s</u>	never is not breathing.		
	Resuscitate (CPR)	Do Not Attempt Resuscitate (DNR/no CPR)			
Check One			Tooggonale (Diffiante of 11)		
Box Only	When not in cardiopulmonary arrest, follow	erders in B. C. and D.			
Section B	MEDICAL INTERVENTIONS. Patient has p	oulse and/or is breathing.			
		-			
	Gomfort Measures Treat with dignity a	nd respect. Keep clean, warn	1, a nd dry.		
803655	Use medication by any route, positionic	ng, wound care and other me:	asures to relieve pain and suffering.		
Check One	Use oxygen, suction and manual treatm	nent of alrway obstruction as	nesded-fer-comfort. Do not-transfer		
Box Only	to hospital for life-sustaining treatment.	- Francier only it comfort neco	is cannot be met in current location.		
DOLOTHY	Limited Additional Interventions Include	se care described chaus. He	n mandiani kanahanna 19 / 80 Julia		
	cardiac monitoring as indicated. Do no	tuse intubation, advanced air	Tinedical Healinein, IV Hulds and		
	ventilation. Transfer to hospital if indica	aled. Avoid intensive care.	may morromono; or modulined:		
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical				
	ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.				
	COUL.				
	— Other Instructions:				
Section	ANTIBIOTICS Treatment for new medical	one dilian.			
~~~~~~	MALDIO HOO HOSHIBITION HEGICAL	<del>Conument,</del>			
	☐ No Antibiotics				
Check One	☐-Antibiotics				
Box Only	<b>~</b>				
Section	Other Instructions:	0.23 199 00 1991 00 1991			
D D	MEDICALLY ADMINISTERED FLUIDS AND medically feasible.	<del>l NUTRI HON. Oral fluids a</del> nd	I nutrition must be offered if		
	Thousany toacisio.				
Check One	No IV fluids (provide other measures to	ssure comfort) — [] No.1	leeding tube		
Box Only in	I IV fluids for a defined trial period		ding tube for a defined trial period		
Each	☐ IV fluids long-term if indicated ——————		ding-tube long-term		
Column	O				
Section	Other Instructions: Discussed with:				
E	Discussed with: ☐ Patient/Resident	The Basis for These Orders	Is: (Must be completed)		
-	Health care agent	Patient's preferences Patient's best interest (pelient lacks capacity or preferences unknown)			
Must be	Gourt-appointed guardian	Medical indications	ment racks capacity or breferences unknown)		
Completed	Health care surrogate	U Medical indications  (Other)			
	Parent-of minor				
	Other:(Specify)				
2.612.010.05					
	Physician Name (Print)	Physician Phone Number	Office Use Only		
Physician Signature (Mandatory)  Date					
				Security Company Company Company Company Company	
COB	Y OF FORM SHALL ACCOMPANY PATI		COMO NICOUNDACO		

REPARAMENTAL DE PROPERTIES	ellanosi Saconel Pilling illinoseen	omplered forms ve	Mark and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state		
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative  Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or					
health care professional(s). This docum	tent reflects those treatment preference	38:	a britoioiair ariare.		
(If signed by surrogate, preferences exp	ressed must reflect patient's wishes as	best understood by su	rrogate.)		
Signature	Name (print)	Relationship (write	"self if pallent)		
Gentact Information Surrogate	Palationalia				
<del>Juliogale</del>	Relationship	Phone Number			
Health Care Professional Preparing	Preparer Title	Phone Number	Date Prepared		
Form	į į	Y H h South I Supr v. 2 sound I it suprement	Batoriopaios		
	Directions for Health Care Professiona	sle.			
Completing POST	Directions to recent Seto-Freedomic	HO.			
- Must be completed by a health care printing indications.	rofessional based on patient preference	<del>is, patient best interest</del>	, and medical		
—POST must be signed by a physician t accordance with facility/community po	:e be valid. Verbal orders are acceptab <del>xlicy.</del>	<del>le with follow-up signat</del>	ure by physician in		
—Photocopies/faxes of signed POST for	ms are legal and valid.				
Using POST					
-Any incomplete section of POST implic	es 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	e <u>offered</u> if medically feasible.				
<ul> <li>IV medication to enhance comfort may be appropriate for a person who has chosen</li> <li>"Comfort Measures Only".</li> </ul>					
Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids —should indicate "Limited Interventions" or "Full Treatment".					
<ul> <li>A person with capacity, or the surrogate of a person without capacity, can request</li> <li>alternative treatment.</li> </ul>					
Reviewing POST					
This POST should be reviewed if:					
<ul> <li>(1) The patient is transferred from one care setting or care level to another, or</li> <li>(2) There is a substantial change in the patient's health status, or</li> <li>(3) The patient's treatment preferences change.</li> </ul>					
Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.					
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005					
COPY OF FORM SHALL ACCO	MPANY PATIENT WHEN TRA	NSFERRED OR C	HSCHARGED		

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

	A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED					
-	E	Physician Orders for Scope of Treatment (POST)  Patient's Last Name				ne
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.    Date of Birth   Physician   Phy			Initial			
1000	Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.				
	A Check One Box Only	Resuscitate (CPR) Do Not Attempt Resuscitation (DNR/ no CPR) (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B, C, and D.				
	Section B B Check One Box Only	□ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.  One □ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and				
	Section	ANTIBIC	TICS - Treatment for ne	w medical conditions:		
	<u>C</u> Check One Box Only	☐ Anti		structions;		
¢	Section D Check One ox Only in Each Column	D   feasible.   □ No IV fluids (provide other measures to assure comfort)   □ No feeding tube   □ IV fluids for a defined trial period   □ Feeding tube for a defined trial period   □ IV fluids long-term if indicated   □ Feeding tube long term			tube be for a defined trial period	
	Section   Discussed with:   The Basis for These Orders Is: (Must be completed)   Patient/Resident   Patient/s preferences   Patient's preferences   Patient's best interest (patient lacks capacity or preferences unknown)   Medical indications   Medical indications   Other: (Specify)   Other:   Oth		***************************************			
	nysician Na rint)		Physician Signature		<u>Date</u>	Physician Phone Number
1		<u>Signature</u>	of Patient, Parent of Mir	ior, or Guardian/Health Car	re Representative	

## STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING PROFESSIONAL SUPPORT SERVICES

CHAPTER 1200-08-34

Freferences have be t me if your preferen	ices change, if you are unable to mak	alth care professional. This form can be reviewed and updated at any e your own health care decisions, the orders should reflect your
Name (print)	Signature	Relationship (write "self" if patient)
<u>\$urrogate</u>	Relationship	Phone Number
Health Care Profession Preparing Form	nal Preparer Title	Phone Number Date Prepared

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

### **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.

#### <u>Using POST</u>

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.

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or
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:
Name:Phone #:Relation:
Address:
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint alternate:
Name: Phone #: Relation:
Address:
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
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.
Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking.  Rehabilitation or any other restorative treatment will not help.
End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.
Yes No 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  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 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 Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Other Instructions, such as burial arrangements, hospice care, etc.:

(Rule 1200-08-3415, continued)
(Attach additional pages if necessary)
Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):
Any organ/tissue
SIGNATURE
Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is no related to you or entitled to any part of your estate.
Signature: DATE:
(Patient)
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.
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 hi 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
WHAT TO DO WITH THIS ADVANCE DIRECTIVE
<ul> <li>Provide a copy to your physician(s)</li> <li>Keep a copy in your personal files where it is accessible to others</li> <li>Tell your closest relatives and friends what is in the document</li> <li>Provide a copy to the person(s) you named as your health care agent</li> </ul>
Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.
(2) Advance Care Plan Form

ADVANCE CARE PLAN

# STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING PROFESSIONAL SUPPORT SERVICES

CHAPTER 1200-08-34

(Rule 1200-08	3-3415, continued)
	(Tennessee)
I. treated by m decisions mys	, hereby give these advance instructions on how I want to be y doctors and other health care providers when I can no longer make those treatment self.
Agent: I wan decision I cou	t the following person to make health care decisions for me. This includes any health care ld have made for myself if able, except that my agent must follow my instructions below:
Name: Relation: Address:	Phone #:
<u>l appoint as a</u>	ent: If the person named above is unable or unwilling to make health care decisions for me, ternate the following person to make health care decisions for me. This includes any health I could have made for myself if able, except that my agent must follow my instructions
Name:	Phone #: Relation:
Address:	
My agent is a HIPAA.	also my personal representative for purposes of federal and state privacy laws, including
time, even if	ve (mark one): □ I give my agent permission to make health care decisions for me at any have capacity to make decisions for myself. □ I do not give such permission (this form hen I no longer have capacity).
adequate com	e: By marking "yes" below, I have indicated conditions I would be willing to live with if given fort care and pain management. By marking "no" below, I have indicated conditions I would to live with (that to me would create an unacceptable quality of life).
☐ ☐ Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes No	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.  Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or
Yes No	move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes No	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 suffice time.

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.

# STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING PROFESSIONAL SUPPORT SERVICES

CHAPTER 1200-08-34

(Rule 1200-08-3415, continued)	
□ □ □ CPR (Cardiopulmonary Resuscitation): To n	nake the heart beat again and restore breathing after it
Yes No has stopped. Usually this involves electric shoc	k, chest compressions, and breathing assistance.
Life Support / Other Artificial Support: Confi	nuous use of breathing machine, IV fluids, medications,
Yes No and other equipment that helps the lungs, heart,	kidneys, and other organs to continue to work.
Yes No rew condition but will not help the main illness	y, blood transfusions, or antibiotics that will deal with a
THE TOURS DAY WAS STOCKED WITH THE STOCKED THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF THE STITLE OF T	
Yes No fluids into a vein, which would include artificially	food and water to a patient's stomach or use of IV
indias into a vent, which would include artificially	delivered nutrition and nydration.
Please sign on page 2	Page 1 of 2
Otherington	VII.— 1000 LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS LOUIS L
Other instructions, such as burial arrangements, hospice ca	are, etc.:
,	
(Attach additional pages if necessary)	
Organ donation: Upon my death, I wish to make the following a	anatomical gift (mark one):
Fig. 8	
☐ Any organ/tissue ☐ My entire body ☐ On	ly the following organs/tissues:
☐ No organ/tissue donation.	
<u>SIGNATURE</u>	
Your signature must either be witnessed by two competent adul	ts 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 e	<u>estate.</u>
Signature:	Date:
Witnesses: (Patient)	
<u>vviulesses.</u>	
1. I am a competent adult who is not named as the agent or	
alternate. I witnessed the patient's signature on this form.	Signature of witness number 1
O them a communicate with the body of the body	
2.1 am a competent adult who is not named as the agent or	
alternate. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any	Signature of witness number 2
portion of the patient's estate upon his or her death under	organization of the control of a
any existing will or codicil or by operation of law.	
witnessed the patient's signature on this form.	
This document may be notarized instead of witnessed:	
STATE OF TENNESSEE COUNTY OF	
VVVIIIVI	

# STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING PROFESSIONAL SUPPORT SERVICES

CHAPTER 1200-08-34

(Rule 1200-08-3415, continue	(Rule	1200	-08-34-	15.	continue
------------------------------	-------	------	---------	-----	----------

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.

	My commission expires:	***************************************
CSC ( PAR / PSC ALL		
Signature of Notary Public		Signature of Notary Public

### 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

Page 2 of 2

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.

- (f) Earthquake Disaster Procedures Plan shall include:
  - Staff duties:
  - 2. Evacuation procedures;
  - 3. Safety procedures; and
  - 4. Emergency services.
- (2) An ACH shall comply with the following:
  - (a) Maintain a detailed log with staff signatures designating training each employee receives regarding disaster preparedness.
  - (b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.
  - (c) Exercise each of the plans listed above annually.
- (3) An ACH shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes:
  - (a) Filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency; and
  - (b) Maintaining documentation of participation that shall be made available to survey staff as proof of participation.
- (4) An ACH shall have a functioning emergency back-up generator adequate to meet the ACH's HVAC and essential needs until regular service is restored. The ACH shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with the local resources.
- (a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.
- (b) The emergency generator shall be operated at the existing connected load and not on dual power. The ACH shall maintain a monthly log and have trained staff familiar with the generator's operation.

Authority: T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1801 Administrative History: Emergency rule filed November 2, 2010; effective through May 1, 2011.

#### 1200-08-36-.18 APPENDIX I.

(1) Physician Orders for Scope of Treatment (POST) Form

COPY-OF-FORM-SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED					
	Physician Orders Patient's Last Name 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, t	then contact physician.	Date of Birth			
Section -A	CARDIOPULMONARY RESUSCITATION (	CPR): Patient has no pulse a	ind/or is not-breathing.		
Check One	☐ Resuscitate (CPR)	<u>Do N</u> ot Attempt <u>R</u> esu	scitation (DNR/no-CPR)		
Box Only	When not in cardiopulmonary arrest, follow-	erders in B, C, and D.			
Section B	MEDICAL INTERVENTIONS. Patient has p	oulse and/ <u>or</u> is breathing.			
Check One Box Only	Limited Additional Interventions Includes care described above. Use medical treatment IV fluids				
0.000000	and-cardiac-monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.				
	Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.				
	Other Instructions:				
Section C	ANTIBIOTICS Treatment for new medical	conditions:			
	☐ No Antibiotics				
Check One	☐ Antibiotics				
Bex-Only	Other Instructions:				
Section D	MEDICALLY ADMINISTERED FLUIDS AND medically feasible.	NUTRITION. Oral fluids and	I nutrition must be offered if		
Check One Box Only in Each Column	☐ No IV fluids (provide other measures to a ☐ IV fluids for a defined trial period period ☐ IV fluids long term if indicated	——————————————————————————————————————	feeding-tube eding-tube for a defined trial eding-tube long-term		
	Other Instructions:		-		
Section E Must be Completed	Discussed with:      Patient/Resident     Patient/s preferences     Patient's best interest (patient lacks capacity or preferences unknown)     Health care surrogate     Parent of minor     Other:    Court appointed guardian preferences unknown)     Wedical indications     Other)				
	LJ Other: (Specify) Physician Name (Print)	Physician Phone Number	Office Use Only		
	Physician Signature (Mandatory)	Date			
C	OPY OF FORM SHALL ACCOMPANY PATIET	TEWHEN TRANSFERRED O	PR DISCHARGED		

		-	
HIPAA PERMITS DISCLOSURE	NECESSARY		SSIONALS AS
Signature of Patient, Parent of Minor, or G	Juardian/Health Care Representative	0	
Significant thought has been given to life to	sustaining treatment. Preferences h	have been expressed to a	a physician and/or
health care professional(s). This docume	nt-reflects those treatment preference	6 <del>8</del> 8 <del>.</del>	
Signature	212-12 (mint)	IS DEST UNGGISTOGG BY SUI	rogate.)
<del>Jighaturo</del>	Name (print)	Relationship (write	-self-if patient)
Contact Information			
Surregate	Relationship	Phone Number	
		FHORE NUMBER	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
	production of this	THORD MAINES	para Hoparaa
E	 Directions for Health Care Profession	nais	<u> </u>
Completing POST			
Must be completed by a health care pro indications.	rfessional based on patient preferen	ces, patient best interest	<del>, and medical</del>
POST must be signed by a physician to accordance with facility/community police	-be valid. Verbal orders are accepta sy.	a <del>ble with follow up signat</del>	ure by physician in
Photocopies/faxes-of-signed-POST form	<del>is are legal and va</del> lid.		
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 fluide and nutrition <u>must</u> always be <u>offered</u> 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 ha	as chosen "Comfort Mear	sures-Only".
—Treatment of dehydration is a measure Interventions" or "Full Treatment".	3 which prolongs life. A person who	Huide should	indicate="Limited
A person with capacity, or the surregal	te of a person without capacity, can	-request alternative treatr	<del>nent.</del>
Reviewing POST			
This POST should be reviewed if:			
(1) The patient is transferred from one	care selling or care level to another	_07	
(2) There is a substantial change in the (3) The patient's treatment preferences	-patient's health status, or	<del>, or</del>	
Draw line through sections A through E a	ind write "VOID" in large letters if PC	OST is replaced or becom	nes invalid.
Approved by Tennessee Department of He	ialth Board for Licensing Health Car	ro Facilities Eshruant 2	2005
		ro r dominoo; r obradir, a;	2000
COPY OF FORM SHALL ACCOM	APANY PATIENT WHEN TR	ANSFERRED OR D	HSCHARGED

DO NOT ALTER THIS FORM!

(1) Physician Orders for Scope of Treatment (POST) Form

	COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN	N TRANSFERRED OR DISCHARGED
E	Physician Orders for Scope of Treatment (POST)	Patient's Last Name
wishes of the completed in	nysician Order Sheet based on the medical conditions and the person identified at right ("patient"). Any section not dicates full treatment for that section. When need occurs, first orders, then contact physician.	First Name/Middle Initial  Date of Birth
Section	CARDIOPULMONARY RESUSCITATION (CPR): Patient ha	s no pulse and/or is not breathing.
<u>A</u> Check One Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and	
Section B	MEDICAL INTERVENTIONS. Patient has pulse and/or is br  ☐ Comfort Measures. Treat with dignity and respect. Keep route, positioning, wound care and other measures to relie manual treatment of airway obstruction as needed for com sustaining treatment. Transfer only if comfort needs of	o clean, warm, and dry. Use medication by any eve pain and suffering. Use oxygen, suction and fort. Do not transfer to hospital for life-cannot be met in current location.
Check One Box Only	<ul> <li>Limited Additional Interventions. Includes care descrit cardiac monitoring as indicated. Do not use intubation ventilation.</li> <li>Transfer to hospital if indicated. Avoid intensive care.</li> </ul>	ped above. Use medical treatment, IV fluids and advanced airway interventions, or mechanical
	☐ Full Treatment. Includes care above. Use intubation ventilation, and cardioversion as indicated. Transfer to he	on, advanced airway interventions mechanical ospital if indicated. Include intensive care.
	Other Instructions:	
Section C	ANTIBIOTICS - Treatment for new medical conditions:	
Check One Box Only	□ No Antibiotics □ Antibiotics Other Instructions:	
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fleasible.  No IV fluids (provide other measures to assure comfort)  IV fluids for a defined trial period  IV fluids long-term if indicated  Other Instructions:	uids & nutrition must be offered if medically  ☐ No feeding tube ☐ Feeding tube for a defined trial period ☐ Feeding tube long-term
Section E	☐ Patient/Resident       ☐ Patient's preferences         ☐ Health care agent       ☐ Patient's best interest (preferences)         ☐ Court-appointed guardian       ☐ Medical indications         ☐ Health care surrogate       ☐ (Other)	ers Is: (Must be completed) patient lacks capacity or preferences unknown)
Completed	☐ Parent of minor ☐ Other: (Specify)	
Physician Na (Print)		Date Physician Phone Number
	Signature of Patient, Parent of Minor, or Guardian/Health Car ve been expressed to a physician and/or health care professional.	

t me if your preferences preferences as best und		our own health care decisions, the orders should reflect your
Name (print)	Signature	Relationship (write "self" if patient)
<u>\$urrogate</u>	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

#### **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.

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

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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:
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:
Name:Phone#:Relation:
Address:
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of
HIRE THAT IS UNACCOPTABLE TO ME MEANS WHEN I have any of the following conditions (you can check as many of these
items as you want):
Permanent Unconscious Condition: I become totally unaware of people or
surroundings with little chance of ever waking up from the come.
Permanent Confusion: 1 become unable to remember, understand or make
decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Dependent in all Activities of Dally Living: I am no longer able to talk clearly
or move by myself. I depend on others for feeding, bathing, dressing and walking.  Rehabilitation or any other restorative treatment will not help.
•
End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to
treatment; chronic and/or damaged heart and lungs, where exvden needed most of
the time and activities are limited due to the feeling of suffocation.
Treatment:
If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct
that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking
"no" means I DO NOT want the treatment.

Yes No	CPR (Cardiopulmonary Resusci	italion): To make the heart beat again an Jsually this involves electric shock, chest	<del>d restore</del>
	compressions, and breathing as	sistance,	
	Life Support/Other Artificial Supp	port: Continuous use of breathing machin	10, IV
Yes No	fluids, medications, and other ecother organs to continue to work	<del>luipment that helps the lungs, heart, kidne</del> fr	eys and
Yes No	Treatment of New Conditions: U will deal with a new condition bu	Jse of surgery, blood transfusions, or anti-	biotics that
	Tube feeding/IV fluids: Use of to	ubes to deliver food and water to patient's	etomach
Yes No	or use of IV fluids into a vein whi hydration.	ich weuld include artificially delivered nutr	ition and
Other instructions, suc	h as burial arrangements, hospice	care, etc.:	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
(Attach additional page	as if nacossani)		
h man adamonar bage	<del>ro II nobobary)</del>		
Organ denation (option	nal): Upon my death, I wish to ma	ke the following anatomical gift (please m	ark-one):
Any organ/tissue	My entire body	Only the following	j <u>organs/lissues:</u>
100			
SIGNATURE			
Your signature should be the person you app to you or entitled to any	<del>ointed as your agent, and at least</del>	etent adults or notarized. If witnessed, ne t one of the witnesses should be someon	ither witness should e who is not related
Signature:	777	——Dete:	
	(Patient)		WARANIES .
Witnesses:			
1. Lam a competent ac	dult who is not named as the agen		
- I witnessed the pation	ent's signature on this form.	Signature of witness num	ber-1
2. I am a competent ac	fult who is not named as the agen	į.	
l am not related to the	ne patient by blood, marriage, or	Signature of witness num	ber-2
the nation!'s estate	d not be entitled to any pertion of upon his or her death under any e	vintina	
- will or codicil or by o	peration of law, I witnessed the	yiptiilig	
— patient's signature o	n this form.		
This document may be	notarized instead of witnessed:		
STATE OF TENNESSE	<del>E</del>		
Fam a Notary Public in	n and for the State and County	named above. The person who signed	1 this instrument is
"patient". The patient p	ersonally appeared before me an	f satisfactory evidence) to be the person d signed above or acknowledged the sign	sature above se hie
or her own. I declare i fraud, or undue influence	under penalty of perjury that the	patient appears to be of sound mind an	d under no duress,
My commission expires	,		
*		Signature of Notary Public	)

## 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

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005 Acknowledgement to Project GRACE for inspiring the development of this form.

(2) Advance Care Plan Form

## **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:
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

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).

	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little
Yes No	chance of ever waking up from the coma.
<u> </u>	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not
<u>Yes No</u>	recognize loved ones or cannot have a clear conversation with them.
	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or
<u>Yes No</u>	move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any

other restorative treatment will not help.  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.
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.  CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.  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.  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.  Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV
Yes No fluids into a vein, which would include artificially delivered nutrition and hydration.  Please sign on page 2  Page 1 of 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/tissue donation.
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: Date:  Witnesses:
1. I am a competent adult who is not named as the agent or alternate. I witnessed the patient's signature on this form.  Signature of witness number 1

## STANDARDS FOR ADULT CARE HOMES - LEVEL 2

CHAPTER 1200-08-36

(Rule 1200-08-36-.18, continued)

2. I am a competent adult who is not named as the agent or alternate. 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.

My commission expires:

Signature of Notary Public

### 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

Page 2 of 2

Authority: T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1805. Administrative History: Emergency rule filed November 2, 2010; effective through May 1, 2011.