University of Iowa Children's Hospital
University of Iowa Health Care

IPOST

Important Information About Iowa Physician Orders for Scope of Treatment

IPOST Definition

The Iowa Physician Orders for Scope of Treatment, known as IPOST, is a medical order that allows a person to communicate their preferences for key life-sustaining treatments, including: resuscitation, general scope of treatment, and artificial nutrition.

IPOST Details

- Signed into law on July 1, 2012
- Form and information available at:
  www.idph.state.ia.us/ipost
- Available for Iowans, regardless of age, who have any of the following:
  - A chronic or critical illness
  - A terminal condition
  - Are frail and elderly

IPOST Details, cont.

- The signed IPOST form belongs to the patient and should be kept with them at all times
- Ideally should be printed on salmon-colored paper, but black/white copies are legal
- May be revoked/changed at any time by the patient or their health care agent (for example, parent or guardian)
- May be signed by an MD, NP, or PA

UI Children's Hospital IPOST Details

- Upon arrival of a patient with a signed IPOST, a health care provider will ensure the preferences indicated on the IPOST are still accurate
- The IPOST form will be presented to the patient's LIP immediately
- Based on IPOST preferences, LIP will enter an order for appropriate code status into Epic and return the IPOST to the patient

UI Children's Hospital IPOST Details, cont.

- The IPOST should stay with the patient throughout their hospitalization and be reviewed for accuracy prior to discharge
- Do not scan the IPOST form into Epic, as it may be revoked or changed at any time by the patient/health care agent

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IPOST FORM

Iowa Physician Orders for Scope of Treatment

HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Iowa Physician Orders for Scope of Treatment (IPOST)

First follow these orders, **THEN** contact the physician, nurse practitioner or physician's assistant. This is a medical order sheet based on the person's current medical condition and treatment preferences. Any **section not completed implies full treatment for that section.** Everyone shall be treated with dignity and respect.

	Last Name
	First/Middle Name
	Date of Birth

A Check one

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

- ☐ CPR/Attempt Resuscitation
- ☐ DNR/Do Not Attempt Resuscitation

B Check one

MEDICAL INTERVENTIONS: Person has a pulse **AND/OR** is breathing.

- ☐ **COMFORT MEASURES ONLY** 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. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*
- ☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. **Do not** use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. ***Transfer*** *to hospital if indicated, may include critical care.*
- ☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes critical care.*

Additional Orders: _____

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C Check one	**ARTIFICIALLY ADMINISTERED NUTRITION** Always offer food by mouth if feasible. ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube.
D	**MEDICAL DECISION MAKING**

Directed by: (listed in order of Iowa Code/Statute for Priority of Surrogates; check only one)

- ☐ Patient
- ☐ Durable Power of Attorney for Health Care
- ☐ Spouse
- ☐ Majority of Adult Children
- ☐ Parents
- ☐ Majority rule for nearest relative
- ☐ Other: _____

Rationale for these orders: (check all that apply)

- ☐ Advance Directives
- ☐ Patient's known preference
- ☐ Limited treatment options
- ☐ Poor prognosis
- ☐ Other: _____

Physician/ARNP/PA signature (mandatory)	Print Physician/ARNP/PA Name	Date	Phone Number
Patient/Resident or Legal Surrogate for Health Care Signature as identified above (mandatory)			Date

SEND IPOST WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON

- For more information or with questions, you may contact any of the following:
  - Paige Volk, MD (PICU)
    paige-volk@uiowa.edu
  - Sheila Frascht, RN (Peds Palliative Care)
    sheila-frascht@uiowa.edu
  - Jane Dohrmann, LISW, ACHP-SW
    Director, Honoring Your Wishes
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