

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

| | | | |
|----------------|-------------|----------------------------------|--|
| Last Name: | First Name: | Middle Initial: | |
| Date of Birth: | Last 4 SSN: | <i>(For Patient Identifiers)</i> | |

| | |
|-----------|---|
| A. | CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. |
| CHECK ONE | If patient is not in cardiopulmonary arrest, follow orders in B and C. |
| | <input type="checkbox"/> Attempt Resuscitation/CPR <i>(Selecting CPR in Section A requires selecting Full Treatment in Section B)</i> |
| | <input type="checkbox"/> Do Not Attempt Resuscitation <i>(DNAR/no CPR/Allow Natural Death)</i> |

| | |
|-----------|--|
| B. | MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. |
| CHECK ONE | <input type="checkbox"/> Full Treatment. In addition to treatment described in Comfort Measures Only and Selected Additional Interventions (<i>see below</i>), use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. <u>TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.</u> |
| | <input type="checkbox"/> Selected Additional Interventions. In addition to treatment described in Comfort Measures Only (<i>see below</i>), use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. <u>TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.</u> |
| | <input type="checkbox"/> Comfort Measures Only. 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. Transfer to hospital only if comfort needs cannot be met in current location. <u>TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.</u> |
| | Additional Orders: _____ |

| | |
|-----------|--|
| C. | MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired. |
| CHECK ONE | <input type="checkbox"/> Long term medically administered nutrition, including feeding tubes. <input type="checkbox"/> Medically administered nutrition, including feeding tubes, for trial period: _____ <input type="checkbox"/> No medically administered nutrition, including feeding tubes. |
| | Additional Orders: _____ |

| | | | |
|----------------------|---|--|--|
| D. | INFORMATION AND SIGNATURES | | |
| CHECK ALL THAT APPLY | Discussed with: | | |
| | <input type="checkbox"/> Patient | <input type="checkbox"/> Agent/DPOA healthcare | <input type="checkbox"/> Parent of minor |
| | <input type="checkbox"/> Health care surrogate | <input type="checkbox"/> Other (<i>specify</i>): _____ | <input type="checkbox"/> Legal guardian |
| | Signature of patient or recognized decision maker (<i>All fields required</i>) | | |
| | By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form. | | |
| | Print name: | Signature: | Relationship: |
| | Address: | | Phone: |
| | Signature of authorized healthcare provider (<i>All fields required</i>) | | |
| | My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences. | | |
| | Print name of authorized provider and Physician: | | Phone: |
| | Signature of authorized provider: | | Date: |

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

| | | |
|----------------|-------------|-----------------|
| Last Name: | First Name: | Middle Initial: |
| Date of Birth: | Last 4 SSN: | |

| | | | |
|-----------------------|---|-----------------------------|------------------------------|
| E. | ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS | | |
| | Healthcare Directive or other Advance Directive | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Durable Power of Attorney for Healthcare Decisions document* | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| *Name of Agent: _____ | | Phone: _____ | |

Health Care Providers Assisting with Form Preparation

| | | |
|-------|--------|--------|
| Name: | Title: | Phone: |
| Name: | Title: | Phone: |

Instructions for Completing TPOPP

- Completing a TPOPP form is always voluntary. TPOPP is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- TPOPP is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- TPOPP must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA; and patient (*or representative*) in compliance with scope of practice, regulation, and state law to be valid.
- Use of original form is strongly encouraged. Photocopies and Faxes of signed TPOPP forms are valid. A copy shall be retained in patient's medical record and accompany the patient to all settings.

Using TPOPP

- Any incomplete section of TPOPP implies full treatment for that section.

SECTION A:

– If found pulseless and not breathing, no defibrillator (*including automated external defibrillators*) or chest compressions should be used on a person if “Do Not Attempt Resuscitation” is selected.

SECTION B:

– 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*).

– Non-invasive positive airway pressure includes continuous positive airway pressure (*CPAP*), bi-level positive airway pressure (*BiPAP*), and bag valve mask (*BVM*) assisted respirations.

Reviewing TPOPP

TPOPP form should be reviewed when:

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

Modifying and Voiding TPOPP

- A patient with capacity can, at any time, request alternative treatment or revoke a TPOPP by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing “VOID” in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or to obtain more forms: TPOPP@practicalbioethics.org

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT