Idaho Health Care Directive Registry

I want to:

- ☐ Store a copy of my health care directive in the Registry.
- ☐ Replace my health care directive now in the registry, file number __________, with a new one.
- ☐ Remove my health care directive from the registry.
- ☐ Request a replacement wallet card (no change to my health care directive now in the Registry)

The personal information below is provided with the understanding that it will be stored in the Idaho Health Care Directive Registry. I certify that the Health Care Directive and Durable Power of Attorney that accompanies this Agreement is my currently effective health care directive, and was duly executed, witnessed and acknowledged in accordance with the laws of the State of Idaho.

I understand that use of the health care directive registry is entirely voluntary, and no one is required to register their living will or durable power of attorney with the Idaho Secretary of State. Registration or non-registration of these types of documents has no effect upon their validity. Registration only makes these documents more accessible in time of emergency.

Fill in all blanks of this Agreement and enclose your Health Care Directive with this Agreement. We recommend that your Directive be witnessed or notarized.

Last Name		First Name	Middle Name
Address		Date of Birth	Telephone Number
City	State		Zip Code

Address to return wallet card and documents **(if different from address above)**

Last Name	First Name	Middle Name
Address		
City	State	Zip Code

____
Signature of Registrant

____
Printed Name

____
Date

Sign and date this Agreement and deliver it to the Office of the Idaho Secretary of State in person or by mail. **Idaho Secretary of State**
State Capitol Building
700 West Jefferson Room E205
Boise ID 83720-0080

Click to Print Form

Idaho Physician Orders for Scope of Treatment (POST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- This form must be signed by an authorized practitioner in **Section E** to be valid
- **If any section is NOT COMPLETE provide the most comprehensive treatment in that section**
- **EMS:** If questions arise contact on-line **Medical Control**

Last name________________________

First name________________________

Date of birth___/___/______

Last four digits of SS # _ _ _ _

☐ Male ☐ Female

Section A — Select 1 OR 2

Cardiopulmonary Resuscitation: Patient is not breathing and/or does not have a pulse

☐ **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions

☐ **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

Additional resuscitation instructions: ________________________

____

Section B — Select only ONE box

Medical interventions: Patient has a pulse and is breathing

☐ **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**

☐ **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.

☐ **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

Section C

Artificial Fluids and Nutrition:

☐ Yes ☐ No Feeding tube

☐ Yes ☐ No IV fluids

Other instructions:________________

Antibiotics and blood products:

☐ Yes ☐ No Antibiotics

☐ Yes ☐ No Blood products

Other instructions: ________________

Section D

Advance Directives: The following documents also exist:

☐ Living Will ☐ DPAHC ☐ Other ________

Section E

☐ **I request that this document be submitted to the Idaho Health Care Directive Registry**

Patient/Surrogate Signature: X ________________________

Print Patient/Surrogate name ________ Relationship (Self, Spouse, etc.) ________ Date __/__/__

Physician/APRN/PA Signature: X ________________ Phone #____-____-______

Print Physician/APRN/PA name ________ ID license number ________ Date __/__/__

Discussed with: ☐ Patient ☐ Spouse ☐ DPAHC ☐ Other ________

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference

*****ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED*****

*****PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED*****

*****COPY OF ORIGINAL LEGALLY VALID*****

Orig 7/2007; Rev 7/2012

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