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

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient's Last Name:	Effective Date of Form: _____ *Form must be reviewed at least annually.*
Patient's First Name, Middle Initial:	Date of Birth:

Section A *Check One Box Only*

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

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

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

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care**.

☐ **Comfort Measures:** 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 unless comfort needs cannot be met in current location.**

*Other Instructions*_____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if life can be prolonged.**
☐ **Determine use or limitation of antibiotics when infection occurs.**
☐ **No Antibiotics** (use other measures to relieve symptoms).

*Other Instructions*_____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids long-term if indicated**	☐ **Feeding tube long-term**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to assure comfort)	☐ **No feeding tube**

*Other Instructions*_____

Section E *Check All That Apply*

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

☐ Patient
☐ Parent of (Unemancipated) Minor
☐ Health Care Agent
☐ Legal Guardian of the Person
☐ Spouse
☐ Other Personal Representative(s)--explain:
_____
_____
_____
_____

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature** (Required):	**Phone #:**

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is preferred and *must be offered*, but form still effective without signature)

I agree that adequate information has been provided and significant thought has been given to life-sustaining treatment. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

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Contact Information			
Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be completed by a health care professional based on patient preferences and medical indications. **Be sure to document basis for the order in the progress notes of the medical record.** Mode of communication (e.g, in person, by telephone, etc.) also should be documented.
- MOST must be signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by attending physician (MD/DO), physician assistant or nurse practitioner in accordance with facility/community policy.
- Some patients or their representatives may choose to sign the document indicating their consent and input. Others, however, may agree with the order but prefer not to sign it. The signature of the patient or their representative is preferred and must be offered, however, the form is still effective is the offer is declined.
- Use of original form is strongly encouraged. Multiple originals of signed MOST forms are acceptable.
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA).
- If there is a HCPOA, a copy should be attached if available.

Reviewing MOST

This MOST must be reviewed at least once a year or when:

- The patient has been 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.

If MOST is revised or becomes invalid, draw a line through front page and write "VOID" in large letters.

Review of this MOST Form must occur upon change in patient's condition or yearly, whichever is sooner

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!