This is a reconstruction of the form provided by North Carolina Medical Society, June, 2006. Comments and highlighting are by LifeTree, Inc.
Yellow: Changes from POST Blue: old language, but cause for question

HIPAA PERMITS DISCLOSURE OF POST 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
No date of birth	*Form must be reviewed at least annually.*
Patient's First Name, Middle Initial:	

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*

Order of these selections has reversed

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

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

☐ **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; also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care**.

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

*Other Instructions*_____ Removed underscore from last half of sentence

Section C *Check One Box Only*

ANTIBIOTICS Negative tone to the word "prolonged"

☐ **Antibiotics if life can be prolonged.**
☐ **Determine use or limitation of antibiotics when infection occurs.** Order of items has reversed
☐ **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.

Order of items has reversed — Order reversed

☐ **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 ~~Resident~~
☐ Parent of (Unemancipated) Minor
☐ Health Care Agent
☐ Legal Guardian of the Person
☐ Spouse
☐ Other Personal Representative(s) ~~—~~ explain:
_____
_____
_____
_____

~~Physician Name~~ **MD/DO, PA, or NP Name** (Print)	~~Physician Signature~~ (Mandatory) **MD/DO, PA, or NP Signature (Required)**	~~MD~~ **Phone #**	~~Date~~

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

This phrase is new, and emphasis - italics - is new

I agree that adequate information has been provided and significant thought has been given to life-sustaining treatment. Treatment preferences have been expressed to ~~a~~ the physician ~~and/or health care professional(s),~~ (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 ~~is~~ 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 Number: Cell Phone #:	
Health Care Professional Preparing Form	Preparer Title	Preferred Phone Number	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 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 ~~optional.~~ Preferred and must be offered, however, the form is still effective i[f] the offer is declined.
- Use of original form is strongly encouraged. Multiple originals of signed MOST forms are acceptable.
- MOST is part of advanced care planning, which also may include a living will and health care power of attorney (HCPOA).
- If there is a HCPOA, please attach a copy if available.

Reviewing MOST

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

- ~~After the person~~ The patient has been transferred from one care setting or care level to another; or
- If there is a substantial change in the person's health status; or
- If the person's treatment preferences change.

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

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

Review Date	Reviewer and location of review	~~Physician~~ MD/DO, PA, or NP Signature (required)	~~Location of Review~~ 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!