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:	Patient's Date of Birth:

Section A *Check One Box Only*

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

☐ **Attempt Resuscitation (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 if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the person
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

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 required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. 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.

You are not required to sign this form to receive treatment.

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 reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be reviewed and signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the 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.
- The signature of the patient or their representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- 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, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N.C. Gen. Stat. 90-21.17.

Reviewing MOST

This MOST must be reviewed at least annually or earlier if:

- The patient is admitted and/or discharged from a health care facility;
- 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 Sections A – E and write "VOID" in large letters.

Revocation of MOST

This MOST may be revoked by the patient or the patient's representative.

Review of MOST

Review Date	Reviewer and Location of Review	MD/DO, PA, or NP Signature (Required)	Signature of Patient or Representative (Required)	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!