HIPAA PER	RMITS DISCLOSURE OF	F MOST TO OTHER H	EALTH CARE PR	ROFESSIONAL	S AS NECESSARY	
CONTRACTOR OF THE PARTY OF THE	Medical Orde Scope of Treatment	(MOST)	Patient's Last Name	e:	Effective Date of Form:	
This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates further treatment for that section. When the need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.		mpleted indicates full	Patient's First Name	e, Middle Initial:	Patient's Date of Birth:	
Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient 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: Patient 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. May consider use of less invasive airway support such as BiPAP or CPAP. 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 indicated 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 if indicated IV fluids for a defined trial period No IV fluids (provide other measures to ensure comfort) Other Instructions					
Check The Appropriate Box	DISCUSSED WITH AND AGREED TO BY: Basis for order must be documented in medical record.	Patient Parent or guardian if p Health care agent Legal guardian of the Attorney-in-fact with health care decisions Spouse	patient is a minor patient power to make	parents and adult che Majority of patient's adult siblings An individual with a with the patient who	s reasonably available ildren s reasonably available an established relationship o is acting in good faith and the wishes of the patient	
MD/DO, PA, o	or NP Name (Print):	MD/DO, PA, or NF	Signature and Da	ate (Required):	Phone #:	
(Signature is re I agree that ade Treatment prefe document reflect If signed by a prepresentative. You are not re	atient, Parent of Minor, quired and must either be quate information has bee erences have been express cts those treatment preferentiation to preferentiation for produced to sign this form sentative Name (print)	on this form or on file) on provided and significated to the physician (MI ences and indicates information ferences expressed must personal representative	ant thought has bee D/DO), physician as rmed consent. treflect patient's we should be provided	en given to life-pressistant, or nurse vishes as best und d on the back of t	rolonging measures. practitioner. This derstood by that	
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HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY Contact Information Patient Representative: Relationship: Cell 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 signed and dated 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 his/her 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. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

• 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

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST							
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



