**HIPAA permits disclosure of 'MOST form' to other Healthcare Professionals as necessary**

# Alaska MOST form
# Medical Orders for Scope of Treatment

This is a Medical Order Sheet. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact provider.

| Last Name | |
|---|---|
| First Name | Middle Name |
| Date of Birth | |

**A** *Check One*

***Treatment options when the person is not breathing and has no pulse.***

☐ Do Not Attempt Resuscitation (DNAR/DNR/Allow Natural Death)

☐ Attempt Resuscitation/CPR

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

**B** *Check One*

***Treatment options when the person has pulse and/or is breathing.***

☐ **Comfort measures only.** Use medication, positioning, 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 for life-sustaining treatment. Transfer **only** if comfort needs cannot be met in current location.

☐ **Limited Interventions.** Includes care described above as necessary. Use medical treatment, IV fluids and cardiac monitor as appropriate. **Transfer** to hospital if necessary. Avoid intensive care.

☐ **Trial of Intensive Therapy.** Includes care described above. Time-limited trial of intubation, mechanical ventilation and/or intensive care if medically indicated. **Transfer** to hospital and intensive care if necessary.

☐ **Full Treatment.** Includes care described above. ACLS or PALS, intubation, mechanical ventilation or other advanced airway interventions, and cardioversion as indicated. **Transfer** to hospital and intensive care if necessary.

*Additional Orders:*

**C** *Check One*

***Antibiotics***

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

☐ Use antibiotics if medically indicated.

*Additional Orders:*

**D** *Check One*

***Artificial Nutrition** (Always offer food by mouth first if feasible and medically appropriate).*

☐ No artificial nutrition.

☐ Time-limited trial of artificial nutrition.

☐ Long-term artificial nutrition if medically indicated.

*Additional Orders:*

**E** *Check One*

***Brief Summary of Medical Condition and Rationale for these orders:*** _____

_____

_____

***Condition and orders discussed with:***

Name: _____

Phone: _____

☐ Patient ☐ Parent of Minor

☐ Health Care Agent appointed by person (POA for Health Care) as designated in POA or Advanced Directive

☐ Court-Appointed Guardian

☐ Health Care Surrogate: _____

***Signatures for Orders***

_____MD/DO/ANP/PA Date: _____

_____MD/DO/ANP/PA (Printed Name) Phone: _____

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|---|---|---|---|---|
| **F** | ***Additional Information*** ☐ NO<br>Medical device such as pacemaker, ICD in place? ☐ YES: Description _____<br>(Consider additional order under section B with criteria for deactivating device.) | | | |
| | Advance Directive (Living Will) | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Organ and Tissue Document of Gift | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Appointed Health Care Agent | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Court-appointed Guardian | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Health Care Surrogate available | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Comfort One orders | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | signed | ☐ YES | ☐ NO | ☐ UNKNOWN |
| | Other _____ | | | |
| **G** | ***1) Name and Contact Information for <u>Primary</u> Health Care Agent/ Guardian/ Surrogate*** | | | |
| | Name: _____<br>Relationship: _____<br>Phone: _____ | | | |
| | ***2) Name and Contact Information for <u>Additional</u> Health Care Agent/ Additional Surrogate*** | | | |
| | Name: _____<br>Relationship: _____<br>Phone: _____ | | | |
| | | | | |

## Reviewing and Revising the MOST form:

Consider reviewing or revising the **MOST** form periodically if:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

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This **MOST** form supersedes any prior **MOST** forms. A health care provider should void any prior **MOST** form by drawing a line through its sections A – E, writing "VOID" in large letters and then signing and dating on the line. *If a **MOST** form is voided without creating a new **MOST** form, **full treatment and resuscitation may be provided.***