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

MOST
Medical Orders for Scope of Treatment

This document is based on this person's medical condition and wishes. Any section not completed indicates a preference for full treatment for that section.

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**

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

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING.

❑ **Full Scope of Treatment**: Use intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, IV fluids, and provide comfort measures. **Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures.**

❑ **Limited Additional Intervention**: Use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments.**

❑ **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 the patient's current location (e.g. hip fracture).**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

❑ **Antibiotics if indicated for the purpose of maintaining life**

❑ **Determine use or limitation of antibiotics when infection occurs.**

❑ **Use of antibiotics to relieve pain and discomfort.**

❑ **No Antibiotics (use other measures to relieve symptoms).**

Other instructions: _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: the provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631.

❑ **Long term IV fluids if indicated**

❑ **IV fluids for a defined trial period. Goal:** _____

❑ **No IV fluids** (provide other measures to ensure comfort)

❑ **Long term feeding tube if indicated**

❑ **Feeding tube for a defined trial period. Goal:** _____

❑ **No feeding tube**

Special instructions _____

Section E *Check The Appropriate Box*

Directions were given:
❑ *Orally*
❑ Written

Patient Preferences as a Basis for This MOST Form:

Basis for order must be documented in medical record.

❑ Adult Patient with decisional capacity
❑ Parent/guardian of minor patient
❑ Surrogate per advance directive
❑ Judicially appointed guardian/durable power of attorney with power to make health care decisions
❑ Spouse
❑ Majority of patient's reasonably available adult children
❑ Parent
❑ Majority of patient's reasonably available nearest living relatives of same relation

❑ Patient does not have an advance medical directive such as a living will or health care power of attorney.
❑ Patient has an advance medical directive such as a living will or health care power of attorney in place. I certify this form is in accordance with the decisions in the current advance medical directive.

Name: Printed: _____ Position: _____ Signature: _____

I agree that adequate information has been provided and significant thought has been given to decisions outlined in this form. Treatment preferences have been expressed to the physician (MD/DO). This document reflects those treatment preferences and indicates informed consent. *If signed by a patient, surrogate or responsible party, preferences expressed must reflect patient's wishes as best understood by that surrogate or responsible party.* **You are not required to sign this form to receive treatment.**

Patient, Surrogate or Responsible Party:	Signature:	Relationship: Contact #:	
Health Care Professional Preparing Form: Print Name	Health Care Professional Preparing Form: Signature	Preferred Phone #:	Date Prepared:
Physician Signature	Physician (Print Name)	Physician Contact Number	

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

INFORMATION FOR PATIENT, SURROGATE OR RESPONSIBLE PARTY OF PATIENT NAMED ON THIS FORM

- The MOST form is always voluntary and is usually for persons with advanced illness. MOST records your wishes for medical treatment in your current state of health. The provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance directive, such as the Kentucky Health Care Power of Attorney, is recommended for all capable adults, regardless of their health status. An advance directive allows you to document in detail your future health care instructions or name a surrogate to speak for you if you are unable to speak for yourself, or both. If there are conflicting directions between an enforceable living will and a MOST form, the provisions of the living will shall prevail.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING MOST

- MOST must be reviewed, prepared and signed by the patient's physician in personal communication with the patient, the patient's surrogate or responsible party.
- MOST must be reviewed and contain the original or electronic signature of the patient's physician to be valid. **Be sure to document the basis in the progress notes of the medical record**. Mode of communication (e.g., in person, by telephone, etc.) should also be documented.
- The signature of the patient, surrogate or a responsible party is required; however, if the patient's surrogate or a responsible party is not reasonably available to sign the original form, a copy of the completed form with the signature or electronic signature of the patient's surrogate or a responsible party must be signed by the patient's physician and placed in the medical record.
- Use of original form is required. **Be sure to send the original form with the patient**.
- **There is no requirement that a patient have a MOST.**

IMPLEMENTING MOST

- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility.

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, the surrogate or the responsible party.

Review of MOST

Review Date	Reviewer and Location of Review	MD/DO Signature (Required)	Signature of Patient, Surrogate or Responsible Party (Required)	Outcome of Review, describing the outcome in each row by selecting one of the following:
				❑ 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

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