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

DC Medical Orders for Scope of Treatment (**MOST**)

Last Name **First Name** **MI**

_____

Date of Birth **Last 4 #SSN (optional)**

___/___/___ ____ ____ ____ ____

Responding providers:
FIRST follow these orders, **THEN** contact physician or nurse practitioner. The MOST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a MOST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

_____

_____

PLEASE email completed form as a pdf document to DC.MOST@dc.gov

A Cardio-Pulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

Check One

***When not in cardiopulmonary arrest, go to part B.**

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation (DNAR) / Allow Natural Death (AND)**
Choosing **DNAR** will include appropriate comfort measures.

B Medical Interventions: Person has pulse and/or is breathing.

Check One

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. **Do not intubate.** May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional Orders: (e.g. dialysis) _____

C Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by an authorized representative, the patient must be mentally incapacitated and the person signing is the legal authorized representative.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — MD/DO/APRN Name ***(required)***	Phone Number
	✗ MD/DO/APRN Signature ***(required)***	Date ***(required)***
PRINT — Patient or Legal Authorized Representative Name		Phone Number
✗ Patient or Legal Authorized Representative Signature ***(required)***		Date ***(required)***

Person has: ☐ Health Care Directive (Living Will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany MOST

KEEP ORIGINAL DC MOST FORM WITH PERSON'S MEDICAL RECORDS

Version 8.16.18

Photocopies and faxes of signed MOST forms are legal and valid. May make copies for records.

See back of form for non-emergency preferences ▶

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

Patient and Additional Contact Information (if any)

Patient Name **Last Name** **First Name** **MI**	Date of Birth ____/____/____	Phone Number
Name of Guardian, Authorized Representative or other Contact Person	Relationship	Phone Number

D Medical Treatment Preferences:

Medically-assisted nutrition
Always offer food and liquids by mouth if feasible.

☐ Trial period of medically-assisted nutrition by tube.
(Goal:_____)

☐ No medically-assisted nutrition by tube.

☐ Long-term medically-assisted nutrition by tube.

Antibiotics:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

Additional orders: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

✗ MD/DO/APRN Signature	Date
✗ Patient or Legal Authorized Representative Signature	Date

Directions for Health Care Professionals:

NOTE: A person with capacity may always consent to or refuse medical care interventions, regardless of information represented on any document, including this one.

Completing MOST

- Completing a MOST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their authorized representative and medical provider based on the person's preferences and medical condition.
- MOST must be signed by a MD/DO/APRN and patient, or their authorized representative, to be valid. Verbal orders are acceptable with follow-up signature by a MD/DO/APRN in accordance with facility/community policy.

Using MOST

Any incomplete section of MOST implies full treatment for that section.

This MOST is valid in all care settings including hospitals until replaced by new physician orders.

The MOST is a set of medical orders.

The MOST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status.

An advance directive allows a person to document in detail his/her future health care instructions and/or name an authorized representative decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation"
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment".
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment".

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing MOST

This MOST should be reviewed periodically whenever:

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.

To void this form, draw a line through "Medical Orders" and write "VOID" in large letters. Any changes require a new MOST.

Review of this MOST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND COPY OF MOST FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED