

Medical Orders for Scope of Treatment (MOST)

Allergies: None known Unable to obtain
List with reactions: _____

Section 1: Code of Status

Note: CPR is not attempted on a patient who has suffered an unwitnessed cardiac arrest.

- Attempt** Cardio Pulmonary Resuscitation (CPR). Automatically designated as C2. Please initial below.
 Do Not Attempt Cardio Pulmonary Resuscitation (DNR).

Section 2: MOST Designation based on document conversations. (Initial appropriate level.)

Medical Treatments Excluding Critical Care Intervention and Resuscitation	
M1: _____	Supportive care, symptom management and comfort measures. Allow natural death. Transfer to higher level of care only if patient's comfort needs not met in current location.
M2: _____	Medical treatments available within location of care. Current location: _____ Transfer to a higher level of care only if patient/ts comfort needs not met in current location.
M3: _____	Full medical treatments excluding critical care.
Critical Care Interventions Requested. Note: consultation will be required prior to admission.	
C0: _____	Critical Care Interventions exclusive of CPR, intubation and/or defibrillation: Patient is expect to benefit from and is accepting of any appropriate investigations and interventions that can be offered except CPR, intubation and/or defibrillation. Do Not Attempt Resuscitation.
C1: _____	Critical Care Interventions excluding intubation.
C2: _____	Critical Care Interventions including intubation.

Section 3: Specific Interventions (Optional. Complete consent forms as appropriate)

- Blood products: Yes No Dialysis: Yes No
 Enteral nutrition: Yes No Non-invasive ventilation: Yes No

Other directions: _____

Surgical Resuscitation Order

- WAIVE DNR for duration of procedure and perioperative period. Attempt CPR as indicated.
 Do not attempt resuscitation during procedure.

Section 4: MOST Order Entered as a Result of: (check all that apply)

- Conversations/Consensus**
- | | | |
|--|-------------|-------------|
| <input type="checkbox"/> Capable adult patient | Name: _____ | Date: _____ |
| <input type="checkbox"/> Representative | Name: _____ | Date: _____ |
| <input type="checkbox"/> Temporary Substitute Decision Maker | Name: _____ | Date: _____ |
- Physician Assessment and:** Adult/SDM informed and aware Adult not capable/SDM not available
- Supporting Documentation** (Copies place on patient chart and sent with patient on discharge.)
- | | |
|--|--|
| <input type="checkbox"/> Previous MOST | <input type="checkbox"/> Provincial No CPR |
| <input type="checkbox"/> Advance Directive | <input type="checkbox"/> Representation Agreement: <input type="checkbox"/> Section 7 <input type="checkbox"/> Section 9 |
| <input type="checkbox"/> Other: _____ | |

Print Name: _____ **Physician's Signature:** _____

Date (DD/MM/YYYY): _____ **MSP #:** _____ **Contact #:** _____

Renewal Date (DD/MM/YYYY): _____