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.

| 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. |
| Critical Care Interventions excluding intubation. |
| 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
☐ Capable adult patient Name: ________________ Date: ________________
☐ Representative Name: ________________ Date: ________________
☐ 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.)
☐ Previous MOST ☐ Provincial No CPR
☐ Advance Directive ☐ Representation Agreement: ☐ Section 7 ☐ Section 9
☐ Other: 

Print Name: ___________________________ Physician’s Signature:____________________

Date (DD/MM/YYYY): _______________________ MSP #: _______________________ Contact #: ______________________

Renewal Date (DD/MM/YYYY): _______________________ 10-111-5171 (LC - Rev. - 04/14)