

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

Legal Name _____
 Last Name / First Name

Date of Birth _____
 dd/mm/yyyy

PHN _____

PART 1 – RESUSCITATION STATUS & MEDICAL TREATMENTS		Most Responsible Practitioner (MRP) (Physician and/or Nurse Practitioner) to initial in the box beside the chosen resuscitation status/treatments (choose only ONE designation)
M1	Supportive care, symptom management and comfort measures only: Allow a natural death. Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location.	
M2	Medical treatments within current location of care excluding critical care interventions, cardiopulmonary resuscitation (CPR), intubation, and/or defibrillation. Current location: _____ Allow a natural death. Transfer to higher level of care only if adult's medical treatment needs cannot be met in current location. Goals of care and interventions are for cure or control of symptoms of illness that do not require critical care interventions, CPR, defibrillation and/or intubation.	
M3	Medical treatments including transfer to higher level of care but excluding critical care interventions, CPR, defibrillation and/or intubation: Allow a natural death. Medical treatments are for cure or control of symptoms of illness. Transfer to a higher level of care may occur if required for diagnostics and treatment.	
C0	Critical care interventions excluding CPR, defibrillation and intubation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered except CPR, defibrillation and intubation.	
C1	Critical care interventions including intubation, but excluding CPR and defibrillation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered except CPR and/or defibrillation.	
C2	Critical care interventions including CPR, defibrillation and/or intubation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered.	

PART 2 – SPECIFIC INTERVENTIONS (if applicable, refer to details in completed Patient Consent Record)			
Blood / Products	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nutritional Support	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Non-Invasive Ventilation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other			

PART 3 – SUPPORTING DOCUMENTATION (check all documents reviewed)			
<input type="checkbox"/> Previous MOST Form	<input type="checkbox"/> Plan of Care	<input type="checkbox"/> Representation Agreement	<input type="checkbox"/> Other
<input type="checkbox"/> No CPR Form (B.C.)	<input type="checkbox"/> Advance Directive	<input type="checkbox"/> Section 9 <input type="checkbox"/> Section 7	

PART 4 – CONSULTATIONS Refer to consent process on reverse (check all individuals consulted)		
<input type="checkbox"/> Capable Adult	<input type="checkbox"/> Representative (name) _____	<input type="checkbox"/> Inter-professional health care team
<input type="checkbox"/> Personal Guardian (Committee) (name) _____	<input type="checkbox"/> Temporary Substitute Decision Maker (name) _____	<input type="checkbox"/> Adult incapable / SDM unavailable

SUMMARY OF MRP ORDER (Physician and/or Nurse Practitioner)			
As the MRP I have considered the documents noted in Part 3 and discussed the benefits, consequences and preferences of the above Order with the individual(s) noted in Part 4.			
Name of MRP (please print)		College ID#	Signature
Date (dd/mm/yyyy)	Time (24:00)	MRP Office Phone #	Adult Location
Sent to MOST Data Entry Office		Date (dd/mm/yyyy)	Initials

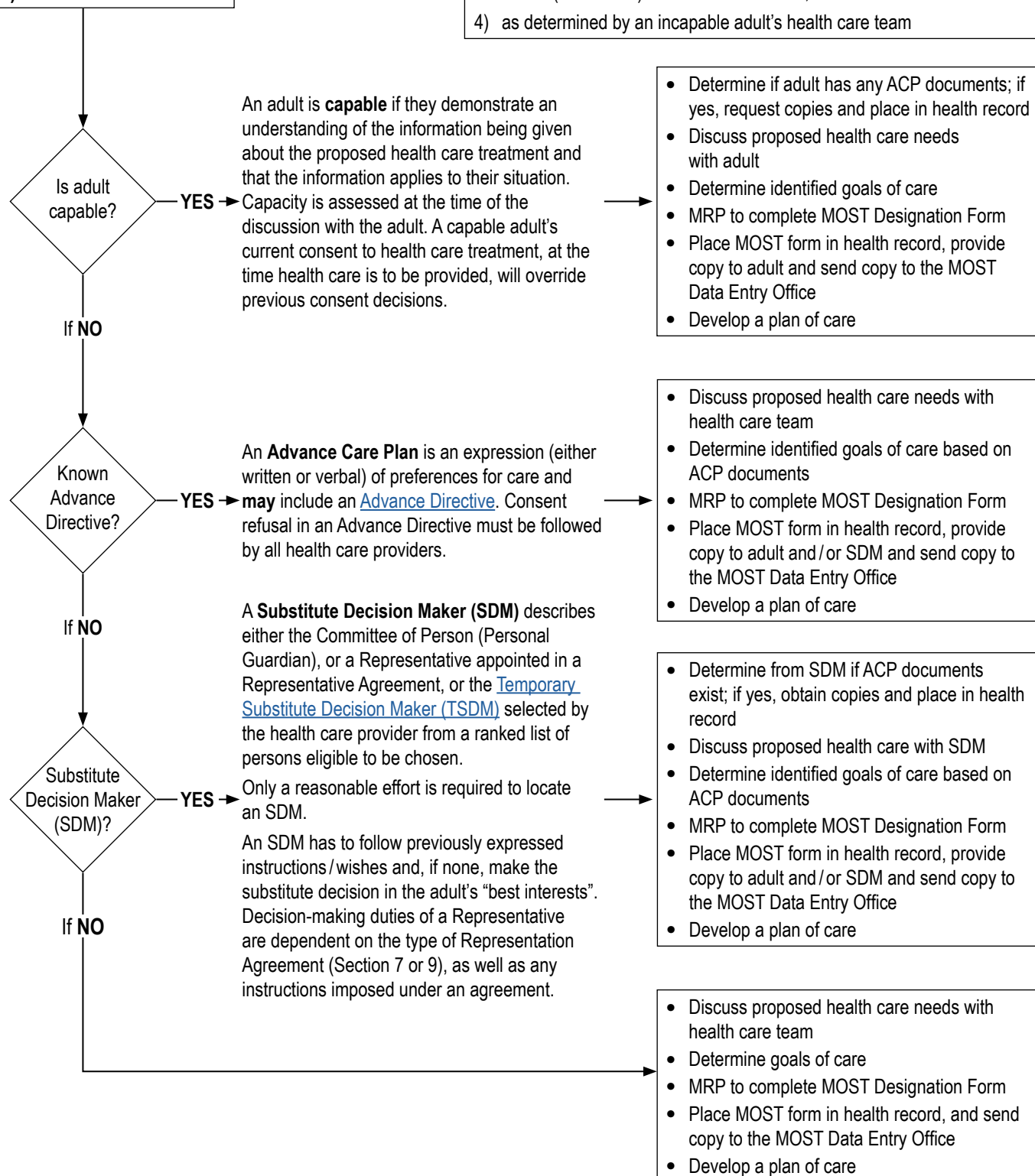
REVALIDATION OF MRP ORDER				
<input type="checkbox"/> MOST FORM Revalidation (No Change)	Date (dd/mm/yyyy)	Name of MRP (print)	College ID#	MRP Signature
Sent to MOST Data Entry Office		Date (dd/mm/yyyy)	Initials	

Send to MOST Data Entry Office at 1-855-980-6180 (toll free)

IF RECEIVED IN ERROR, NOTIFY INTERIOR HEALTH INFORMATION PRIVACY & SECURITY
 TOLL FREE AT 1-855-980-5020

SUMMARY OF PROCESS TO DETERMINE MOST DESIGNATION

NEED FOR MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) IDENTIFIED



KEY MESSAGE

Advance Care Planning (ACP) + MOST informs an adult's "Plan of Care". The priority sequence for obtaining consent is:

- 1) as communicated by a capable adult. A capable adult can change their decision about previous instructions; or
- 2) as written in an adult's Advance Directive, if known; and determine if other personal planning documents exist; or,
- 3) as communicated between an incapable adult's Substitute Decision Maker (if available) and health care team; or
- 4) as determined by an incapable adult's health care team