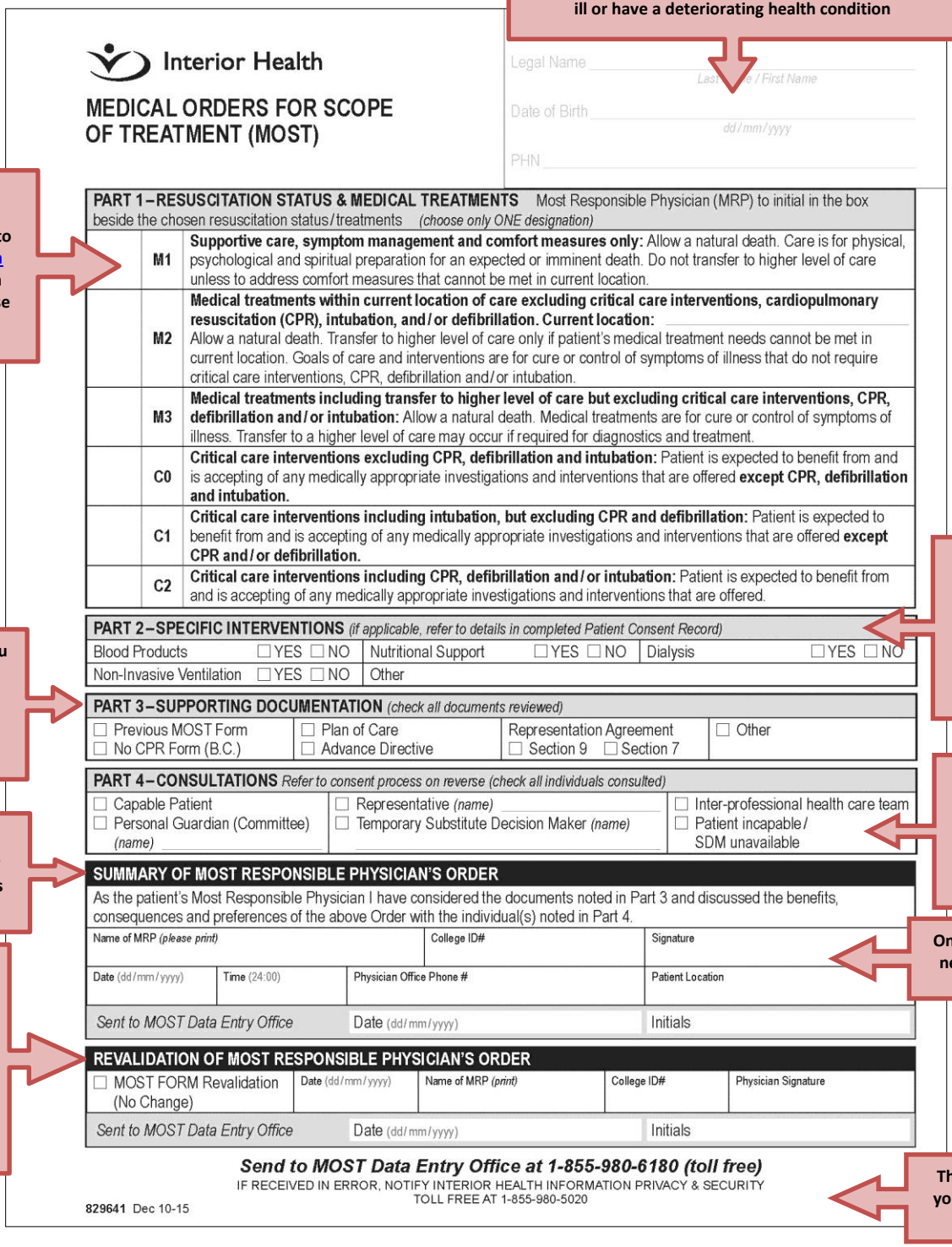
Overview of the MOST Designation Form

Tool to communicate medical orders to your health care team and ambulance services.

Completed for adults (19 and older) who are seriously ill or have a deteriorating health condition



Interior Health

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 Physician (MRP) 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 patient'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:** Patient 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:** Patient 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:** Patient 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 ☐ YES ☐ NO	Nutritional Support ☐ YES ☐ NO	Dialysis ☐ YES ☐ NO
Non-Invasive Ventilation ☐ YES ☐ NO	Other	

PART 3 – SUPPORTING DOCUMENTATION *(check all documents reviewed)*

☐ Previous MOST Form ☐ No CPR Form (B.C.)	☐ Plan of Care ☐ Advance Directive	Representation Agreement ☐ Section 9 ☐ Section 7	☐ Other

PART 4 – CONSULTATIONS *Refer to consent process on reverse (check all individuals consulted)*

☐ Capable Patient ☐ Personal Guardian (Committee) *(name)* _____	☐ Representative *(name)* _____ ☐ Temporary Substitute Decision Maker *(name)* _____	☐ Inter-professional health care team ☐ Patient incapable / SDM unavailable

SUMMARY OF MOST RESPONSIBLE PHYSICIAN'S ORDER

As the patient's Most Responsible Physician 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)	Physician Office Phone #	Patient Location
Sent to MOST Data Entry Office	Date (dd/mm/yyyy)		Initials

REVALIDATION OF MOST RESPONSIBLE PHYSICIAN'S ORDER

☐ MOST FORM Revalidation (No Change)	Date (dd/mm/yyyy)	Name of MRP *(print)*	College ID#	Physician 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

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Your doctor will choose one designation. Refer to MOST Designation Explanation for an explanation of these designations

It is important for you to share your Advance Care Plan. Has this been noted in this section?

As long as you are capable, you will be consulted about this form.

If your situation changes or you wish to review your MOST form, discuss this with your doctor. Otherwise, your doctor will review the MOST as required.

Additional information is noted here by your physician. Not everyone will need this section completed.

Previously expressed instructions/wishes of Capable Adult must be followed by Substitute Decision Maker

Only your physician will need to sign the form.

This form is stored in your electronic health record.

Keep a copy of this form available for ambulance paramedics if an emergency 911 call occurs.

August 2016