Regional Order Set

Medical Orders for Scope of Treatment (MOST)

 PATIENT LABEL

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**

- ☐ Capable adult patient Name: ____________ Date: ____________
- ☐ Representative Name: ____________ Date: ____________
- ☐ Temporary substitute decision maker (SDM) 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
- ☐ Advance directive
- ☐ Other: ____________
- ☐ Provincial no CPR
- ☐ Representation agreement: ☐ Section 7 ☐ Section 9

Print name: ____________ **MSP #:** ____________

Renewal date (DD/MM/YYYY): ____________ **Contact #:** ____________

Physician signature: ____________ **College ID:** ______ **Date:** ________ **Time:** _____