**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

# Colorado Medical Orders for Scope of Treatment (*MOST*)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

| Last Name | | |
|---|---|---|
| First Name/Middle Name | | |
| Date of Birth | | Sex |
| Hair Color | Eye Color | Race/Ethnicity |

## A — Check One Box Only

**CARDIOPULMONARY RESUSCITATION (CPR)** **Person has no pulse and is not breathing.**

☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death

☐ **Yes CPR** Attempt Resuscitation/ CPR

*When not in Cardiopulmonary arrest, follow orders **B**, **C**, and **D***

## B — Check One Box Only

**MEDICAL INTERVENTIONS** **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only:** Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.
***Do not transfer*** to hospital for life-sustaining treatment.
***Transfer only*** if comfort needs cannot be met in current location; **EMS**-Contact medical control.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care;* **EMS**-Contact medical control.

☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
***Transfer*** *to hospital if indicated. Includes intensive care.* **EMS**-Contact medical control.

*Additional Orders:* _____ (**EMS=*Emergency Medical Services***)

## C — Check One Box Only

**ANTIBIOTICS**

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics when comfort is the goal.

☐ Use antibiotics.

*Additional Orders:* _____

## D — Check One Box Only

**ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION**

*******Always offer food & water by mouth if feasible********

☐ No artificial nutrition/hydration by tube. **(NOTE: Special rules for *proxy by statute* on page 2)**

☐ Patient has executed a "Living Will" ☐ Patient has not executed a "Living Will"

☐ Defined trial period of artificial nutrition/hydration by tube.
(Length of trial: _____ Goal:_____)

☐ Long-term artificial nutrition/hydration by tube.

*Additional Orders:* _____

## E — Check All That Apply

**DISCUSSED WITH:**

☐ Patient

☐ Agent under Medical Durable Power of Attorney

☐ Proxy (per statute C.R.S. 15-18.5-103(6))

☐ Guardian

☐ Other:_____

***(SECTION RESERVED FOR FUTURE USE)***

**SUMMARY OF MEDICAL CONDITION(S):**

| **Physician/APN /PA Signature** (mandatory) | **Print Physician/APN/PA** ***Name, Address and Phone Number*** | **Date** |
|---|---|---|
| **Colorado License #:** | | |

**HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

## SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

## SIGNATURE OF PATIENT, AGENT, GUARDIAN, OR PROXY BY STATUTE (MANDATORY)

Significant thought has been given to the desired scope of end-of-life treatment and these instructions. Preferences have been discussed and expressed to a health care professional. This document reflects those treatment preferences, which may also be documented in a MDPOA, CPR Directive, Living Will, or other advance directive (attached if available). To the extent that my prior advance directives do not conflict with these *Medical Orders for Scope of Treatment*, my prior advance directives shall remain in full force and effect.

***(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)***

| *Signature* | *Name (Print)* | *Relationship/ Surrogate status (write "self" if patient)* | *Date Signed (Revokes all previous MOST forms)* |
|---|---|---|---|
| *Primary Contact Person for the Patient* | *Relationship and/or **MDPOA**, **Proxy*** | *Phone Number/Contact Information* | |
| *Health Care Professional Preparing Form* | *Preparer Title* | *Phone Number* | *Date Prepared* |
| *Hospice Program (if applicable)* | *Address* | *Phone Number* | *Date Enrolled* |

### DIRECTIONS FOR HEALTH CARE PROFESSIONALS

**COMPLETING THESE *MEDICAL ORDERS***

- Must be completed by a health care professional based on patient preferences and medical indications.
- These *Medical Orders* must be signed by a physician, advanced practice nurse, or physician assistant to be valid. *Physician Assistants must include physician name and contact information.*
- Verbal orders are acceptable with follow-up signature by physician or advanced practice nurse in accordance with facility policy.
- Original form strongly encouraged. Photocopy, fax, and electronic image of signed *MOST* forms are legal and valid.

**USING THESE *MEDICAL ORDERS***

- Any section of these *Medical Orders* not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Comfort care is never optional; Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- A person who chooses "Comfort Measures Only" or "Limited Additional Interventions," should not be entered into a trauma system. *EMS should contact Medical Control for further orders or direction regarding transfers.*
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns with the patient or authorized surrogate and revise orders with consent of patient or surrogate.
- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer to the patient to another provider or facility and provide appropriate care in the meantime.
- **Proxy by statute is a decision maker selected through a proxy process** according to C.R.S. 15-18.5-103(6), who *may not* decline artificial nutrition/hydration (ANH) without an attending physician and a second physician trained in neurology certifying that provision of ANH would merely prolong the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.

**REVIEWING THESE *MEDICAL ORDERS***

These *Medical Orders* should be reviewed regularly and when the person is transferred from one care setting or care level to another, there is a substantial change in the person's health status, the person's treatment preferences change, or when contact information changes.

### REVIEW OF THIS *MOST* FORM

| Review Date | Reviewer | Location of Review | Review Outcome |
|---|---|---|---|
| | | | ☐No Change ☐Form Voided ☐New Form Completed |
| | | | ☐No Change ☐Form Voided ☐New Form Completed |
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