



Regional Order Set

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.	
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 Provincial no CPR
 - Advance directive Representation agreement: Section 7 Section 9
 - Other: _____

Print name: _____ MSP #: _____

Renewal date (DD/MM/YYYY): _____ Contact #: _____

Physician signature: _____ College ID: _____ Date: _____ Time: _____

