

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ALASKA PIONEER HOMES

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ALASKA MOST FORM

Attached is the Alaska MOST (Medical Orders for Scope of Treatment) Form.

This form is to be filled out by your medical provider after discussion with you and your family regarding your medical choices. You can change your mind about your medical care choices at any time. If you do change your mind, your medical provider will need to complete and sign a new MOST form, as the information contained in the form are approved medical orders.

The MOST form will help your medical provider, the Pioneer Home staff and hospital staff understand clearly and quickly what kind of treatment you do or do not want.

**Alaska MOST form
Medical Orders for Scope
of Treatment**

This is a Medical Order Sheet. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact provider.

Last Name

First Name

Middle Name

Date of Birth

A

Check
One

Treatment options when the person is not breathing and has no pulse.

- Do Not Attempt Resuscitation (DNAR/DNR/Allow Natural Death)
- Attempt Resuscitation/CPR

When not in cardiopulmonary arrest, follow orders in B, C, and D

B

Check
One

Treatment options when the person has pulse and/or is breathing.

- Comfort measures only.** Use medication, 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.
- Limited Interventions.** Includes care described above as necessary. Use medical treatment, IV fluids and cardiac monitor as appropriate. **Transfer** to hospital if necessary. Avoid intensive care.
- Trial of Intensive Therapy.** Includes care described above. Time-limited trial of intubation, mechanical ventilation and/or intensive care if medically indicated. **Transfer** to hospital and intensive care if necessary.
- Full Treatment.** Includes care described above. ACLS, intubation, mechanical ventilation or other advanced airway interventions, and cardioversion as indicated. **Transfer** to hospital and intensive care if necessary.

Additional Orders:

C

Check
One

Antibiotics

- No antibiotics. Use other measures to relieve symptoms.
- Determine use or limitation of antibiotics when infection occurs, with comfort as goal.
- Use antibiotics if medically indicated.

Additional Orders:

D

Check
One

Artificial Nutrition (Always offer food by mouth first if feasible and medically appropriate).

- No artificial nutrition.
- Time-limited trial of artificial nutrition.
- Long-term artificial nutrition if medically indicated.

Additional Orders:

ECheck
One**Brief Summary of Medical Condition and Rationale for these orders:** _____
_____**Condition and orders discussed with:**

_____ (Name)

_____ (Phone)

 Patient Parent of Minor Health Care Agent appointed by person (POA for Health Care) as designated in POA or Advanced Directive Court-Appointed Guardian Health Care Surrogate: _____**Signatures for Orders**

_____ MD/DO/ANP/PA

Date: _____

_____ MD/DO/ANP/PA (Printed Name) Phone: _____

HIPAA permits disclosure of 'MOST form' to other Healthcare Professionals as necessary**F****Additional Information**

Advance Directive (Living Will)

 YES NO UNKNOWN

Organ and Tissue Document of Gift

 YES NO UNKNOWN

Appointed Health Care Agent

 YES NO UNKNOWN

Court-appointed Guardian

 YES NO UNKNOWN

Health Care Surrogate available

 YES NO UNKNOWN

Comfort One orders signed

 YES NO UNKNOWN

Other _____

 YES NO UNKNOWN**G****1) Name and Contact Information for Primary Health Care Agent/ Guardian/ Surrogate**

_____ (Name)

_____ (Relationship)

_____ (Phone)

2) Name and Contact Information for Additional Health Care Agent/ Additional Surrogate

_____ (Name)

_____ (Relationship)

_____ (Phone)

Reviewing and Revising the MOST form:

Consider reviewing or revising the **MOST** form periodically if:

- (1) The person is transferred from one care setting or care level to another, or
 - (2) There is a substantial change in the person's health status, or
 - (3) The person's treatment preferences change.
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This **MOST** form supersedes any prior **MOST** forms. A health care provider should void any prior **MOST** form by drawing a line through its sections A – E, writing “VOID” in large letters and then signing and dating on the line. *If a **MOST** form is voided without creating a new **MOST** form, **full treatment and resuscitation may be provided.***