STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA PIONEER HOMES

SEAN PARNELL, GOVERNOR

P.O. BOX 110690
JUNEAU, ALASKA 99811-0690
PHONE: (907) 465-4416
FAX: (907) 465-4108
TTY: (907) 465-2205

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.

HIPAA permits disclosure of 'MOST form' to other Healthcare Professionals as necessary

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:

E
Check 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 <u>Primary</u> Health Care Agent/ Guardian/ Surrogate

_____ (Name)

_____ (Relationship)

_____ (Phone)

2) Name and Contact Information for <u>Additional</u> 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.

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.***