


# Overview of Interior Health's MOST Designation Form

This document is a tool to communicate medical orders to the health care team and ambulance services.

 Interior Health  
**MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)**

Completed for any adult (19 and older), especially one with a chronic or deteriorating health condition

Legal Name \_\_\_\_\_  
Last Name / First Name  
Date of Birth \_\_\_\_\_  
dd/mm/yyyy  
PHN \_\_\_\_\_

**Part 1:** You and your MRP (physician or nurse practitioner) will choose one designation. Refer to the [MOST Designation Explanation](#) for additional information.

**PART 1 – RESUSCITATION STATUS & MEDICAL TREATMENTS** Most Responsible Practitioner (MRP) (Physician and/or Nurse Practitioner) to initial in the box beside the chosen resuscitation status/ treatments (choose only ONE designation)

<b>M1</b>	Supportive care, symptom management and comfort measures only: Allow a natural death. Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location.
<b>M2</b>	Medical treatments within current location of care excluding critical care interventions, cardiopulmonary resuscitation (CPR), intubation, and/or defibrillation. Current location: _____ Allow a natural death. Transfer to higher level of care only if adult's medical treatment needs cannot be met in current location. Goals of care and interventions are for cure or control of symptoms of illness that do not require critical care interventions, CPR, defibrillation and/or intubation.
<b>M3</b>	Medical treatments including transfer to higher level of care but excluding critical care interventions, CPR, defibrillation and/or intubation: Allow a natural death. Medical treatments are for cure or control of symptoms of illness. Transfer to a higher level of care may occur if required for diagnostics and treatment.
<b>C0</b>	Critical care interventions excluding CPR, defibrillation and intubation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered <b>except CPR, defibrillation and intubation.</b>
<b>C1</b>	Critical care interventions including intubation, but excluding CPR and defibrillation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered <b>except CPR and/or defibrillation.</b>
<b>C2</b>	Critical care interventions including CPR, defibrillation and/or intubation: Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered.

**Part 2:** Additional information is included by your MRP. Not everyone will need this section completed.

**PART 2 – SPECIFIC INTERVENTIONS** (if applicable, refer to details in completed Patient Consent Record)

Blood / Products	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nutritional Support	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Non-Invasive Ventilation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other			

**Part 4:** Your MRP will discuss the MOST Order with you, or your SDM or TSDM. Previously expressed instructions/ wishes must be followed by your SDM.

**PART 3 – SUPPORTING DOCUMENTATION** (check all documents reviewed)

<input type="checkbox"/> Previous MOST Form	<input type="checkbox"/> Plan of Care	Representation Agreement	<input type="checkbox"/> Other
<input type="checkbox"/> No CPR Form (B.C.)	<input type="checkbox"/> Advance Directive	<input type="checkbox"/> Section 9 <input type="checkbox"/> Section 7	

**PART 4 – CONSULTATIONS** Refer to consent process on reverse (check all individuals consulted)

<input type="checkbox"/> Capable Adult	<input type="checkbox"/> Representative (name) _____	<input type="checkbox"/> Inter-professional health care team
<input type="checkbox"/> Personal Guardian (Committee) (name) _____	<input type="checkbox"/> Temporary Substitute Decision Maker (name) _____	<input type="checkbox"/> Adult incapable / SDM unavailable

**Part 3:** Do you have an advance care plan and has it been shared with your loved ones and your MRP? Resource: ['My Voice' Advance Care Planning Guide](#)

Your MOST Form will be reviewed annually as required by your MRP or upon your request.

**SUMMARY OF MRP ORDER (Physician and/or Nurse Practitioner)**

As the MRP I have considered the documents noted in Part 3 and discussed the benefits, consequences and preferences of the above Order with the individual(s) noted in Part 4.

Name of MRP (please print)	College ID#	Signature
Date (dd/mm/yyyy)	Time (24:00)	MRP Office Phone #
Sent to MOST Data Entry Office		Adult Location
Date (dd/mm/yyyy)	Initials	

**REVALIDATION OF MRP ORDER**

<input type="checkbox"/> MOST FORM Revalidation (No Change)	Date (dd/mm/yyyy)	Name of MRP (print)	College ID#	MRP Signature
Sent to MOST Data Entry Office		Date (dd/mm/yyyy)	Initials	

Your MRP will sign the form to confirm discussions have taken place with you or your SDM, except in emergency situations.

This form is stored in your electronic health record.

Send to MOST Data Entry Office at 1-855-980-6180 (toll free)  
IF RECEIVED IN ERROR, NOTIFY INTERIOR HEALTH INFORMATION PRIVACY & SECURITY  
TOLL FREE AT 1-855-980-5020

Keep a copy of this form available for ambulance paramedics if an emergency 911 call occurs.