HIPAA PERMITS DISCLOSURE OF SOUTH DAKOTA MOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

MEDICAL ORDERS FOR SCOPE OF TREATMENT

SOUTH DAKOTA MOST

LAST NAME _____

FIRST NAME _____

MIDDLE INITIAL _____

DATE OF BIRTH _____ (mm/dd/yyyy)

FIRST follow these orders, **THEN** contact medical provider. This is a Medical Order Sheet based on the patient's current medical condition and wishes. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions. The South Dakota MOST complements an advance health care directive and is not intended to replace that document.

Does patient have an advance health care directive? Yes ☐ No ☐

PATIENT'S DIAGNOSIS OF TERMINAL CONDITION:

_____

_____

_____

GOALS OF CARE:

_____

_____

_____

Check One

A. CARDIOPULMONARY RESUCITATION (CPR): PATIENT HAS NO PULSE AND IS NOT BREATHING

☐ CPR/Attempt Resuscitation (requires full intervention in section B)

☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

Check One

B. MEDICAL INTERVENTIONS: PATIENT HAS PULSE AND IS BREATHING, OR HAS PULSE AND IS NOT BREATHING.

☐ Full Intervention: Treatment Goal: Full intervention including life support measures in the intensive care unit. In addition to treatment described in Comfort Measures and Selective Treatment below, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

☐ Selective Treatment: Treatment Goal: Stabilization of medical condition. In addition to treatment described in Comfort Measures below, use medical treatment, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Comfort Measures Only (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

ADDITIONAL ORDERS: (e.g. dialysis, etc.)

_____

_____

_____

_____

Check One in Each Column

C. ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION:

ALWAYS OFFER FOOD AND FLUIDS BY MOUTH AS TOLERATED.

Based on the Provider's medical judgment:

	YES	NO
1. Will artificially administered nutrition and hydration be unable to prolong life?	☐	☐
2. Will artificially administered nutrition and hydration be more burdensome than beneficial?	☐	☐
3. Will artificially administered nutrition and hydration cause significant physical discomfort?	☐	☐
4. Has patient previously expressed a desire to forgo artificially administered nutrition and hydration by tube?	☐	☐

In order for artificially administered nutrition and hydration to be withheld, there must be a "YES" answer to one or more of questions 1-4 above.

Check One

D. INFORMED CONSENT DISCUSSION:

_____ had an informed consent discussion with patient or authorized representative.

Name of Medical Provider (MD, DO, NP or PA)

DISCUSSED WITH: ☐ Patient ☐ Authorized Representative _____

(Name of Representative)

Check All That Apply

The basis for these orders is:

☐ Patient's declaration (can be verbal or nonverbal).

☐ Patient's Authorized Representative (patient without capacity).

☐ Patient's Advance Directive (if indicated, patient has completed an additional document that provides guidance for treatment measures if he /she loses medical decision-making capacity).

☐ Resuscitation would be medically non-beneficial.

This form is voluntary and the signatures below indicate that the medical orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interests of the patient who is the subject of the document.

PRINT MEDICAL PROVIDER NAME	MEDICAL PROVIDER SIGNATURE (MANDATORY)	MEDICAL PROVIDER PHONE	DATE (MANDATORY)

PRINT PATIENT OR REPRESENTATIVE NAME	PATIENT OR REPRESENTATIVE SIGNATURE (MANDATORY)	DATE (MANDATORY)

REPRESENTATIVE RELATIONSHIP	REPRESENTATIVE ADDRESS	REPRESENTATIVE PHONE NUMBER

ENSURE PATIENT HAS THE CURRENT FORM.

PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.

INFORMATION FOR HEALTH CARE PROVIDERS

Last Name: _____ First Name: _____ DOB: ___/____/_____

COMPLETING SOUTH DAKOTA MOST

a. Must be completed by a physician, nurse practitioner or physician assistant based on patient's preferences and/or best interests, and medical indications.
b. **South Dakota MOST** must be signed and dated by a MD, DO, NP or PA to be valid.
c. **South Dakota MOST** must be signed by the patient or the patient's authorized representative.
d. Use of original form is strongly encouraged. Photocopies and faxes of signed and dated **South Dakota MOST** are legal and valid.

USING SOUTH DAKOTA MOST (Additional information available at: www.sdaho.org/MOST)

1. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions.

2. Artificial nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial, would cause significant physical discomfort, or patient had previously expressed a personal desire to forgo artificial nutrition by tube.

3. The determination of burden refers to the provision of artificial nutrition or hydration itself and not the quality of continued life of the patient.

4. A patient with capacity may revoke the **South Dakota MOST** at any time and request alternate treatment. Additionally, an authorized representative may revoke the MOST only if the MOST was executed by the authorized representative.

5. If there is a conflict between the patient's MOST document and the patient's written directives in any previously executed and unrevoked durable power of attorney or living will, the health care provider will treat the patient in accordance with the instructions in the MOST.

The duty of medicine is to care for patients even when they cannot be cured. Physicians, nurse practitioners and physician assistants, and their patients must evaluate the use of technology at their disposal based on available information. Judgments about the use of technology to maintain life must reflect the inherent dignity of the patient and the purpose of medical care. Everyone is to be treated with dignity and respect.

REVIEWING SOUTH DAKOTA MOST

It is recommended that this **South Dakota MOST** be reviewed periodically, such as when the patient is transferred from one care setting or care level to another, or there is a substantial change in the patient's health status. A patient may revoke a MOST at any time by:

a. Destroying or defacing the MOST with the intent to revoke;
b. A written revocation of the MOST, signed and dated by the patient; or
c. An oral expression of the intent to revoke the MOST, in the presence of a witness 18 years of age or older who signs and dates in writing, confirming that such expression of intent was made.

NOTE: An authorized representative may not revoke a MOST unless the MOST was executed by the authorized representative. Any such revocation by the authorized representative must be in writing.

A revocation is effective upon communication to the health care provider. A health care provider who is informed of a revocation shall record the date and time of the notification of revocation in the patient's medical record.

A new **South Dakota MOST** form should be completed if the patient wishes to make any substantive change to treatment goal(s) (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical record. To void the **South Dakota MOST** form, draw line through sections A through D and write "VOID" in large letters. This must be signed and dated.

REVIEW OF THIS SOUTH DAKOTA MOST FORM

REVIEW DATE AND TIME	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed

ENSURE PATIENT HAS THE CURRENT FORM.
PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.