New Mexico Medical Orders For Scope of Treatment (MOST)

First follow these orders, then contact the physician, APN, or PA. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form.

Last Name/First/Middle Initial

Address

City/State/Zip

Date of Birth (mm/dd/yyyy)

The New Mexico MOST is an advance healthcare directive or ***healthcare decision*** *and must be honored in accordance with state law (NMSA 1978§24-7A-1 et seq.) If there is a conflict between this directive and an earlier directive, the most current choices made by the patient or the Healthcare Decision Maker shall control.*

A *Check One*

EMERGENCY RESPONSE SECTION: Person has no pulse or is not breathing.

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

When not in Cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: Patient has a pulse

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

☐ **Limited Additional Interventions:** May include care as described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid Intensive Care.**

☐ **All indicated interventions:** May include care as described above. **Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes Intensive Care.**

Additional Orders:

_____

C *Check One*

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

(Always offer food and liquids by mouth if feasible and desired.)

☐ No artificial nutrition. ☐ No artificial hydration.

☐ Time-limited trial of artificial nutrition. ☐ Time-limited trial of artificial hydration.

Goal of the trial: _____

☐ Long-term artificial nutrition/hydration.

D

Discussed with: ☐ Patient ☐ Healthcare Decision maker ☐ Parent of Minor ☐ Court Appointed Guardian ☐ Other

☐ Interpreter used

Signature of Physician: My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Physician Name (required, please print)	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient or Healthcare Decision Maker: By signing this form, I declare I have had a conversation with the healthcare provider. I direct the healthcare provider and others involved in care to provide healthcare as described in this directive.

Signature (required)	Name (print)	Date
Address	Phone	Relationship to the Patient

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

For easy Identification, please print on "Wausau Astrobright Terra Green" 65 lb paper. However, plain white photocopies, faxes and electronic scans are valid.

	Last Name/First/Middle Initial **Address** **City/State/Zip** **Date of Birth (mm/dd/yyyy)**

DESIGNATION OF HEALTHCARE DECISION MAKER

(This designation can be completed only by a patient with decisional capacity)

The Designation of Healthcare Decision Maker is an advance healthcare directive and must be honored in accordance with state law (NMSA 1978§24-7A-1 et seq.) If there is a conflict between this directive and an earlier directive, the most current choice(s) made by the patient shall control.

If the time comes when I lack capacity and there are medical decisions that need to be made that are beyond the individual instructions as set forth in this MOST, I designate the following individual as my agent to make healthcare decisions for me:
Name:
Address:
Telephone Number: (if available)
If my agent listed above is not willing, able or available to make healthcare decisions for me, I designate the following individual as my alternate agent for the purposes of making healthcare decisions for me:
Name:
Address:
Telephone Number:

Signature of Patient:	Date:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Directions for Healthcare Professional

Completing MOST

- Must be completed by healthcare professional based on patient preferences and medical indications.
- Choice of Medical Intervention and Cardiopulmonary Resuscitation status must be clinically aligned:
  Example: "Comfort Care" and "Attempt Resuscitation" are contradictory choices.
- MOST must be signed by a physician and the patient/decision maker to be valid. Verbal orders are acceptable with follow-up signature by the physician in accordance with facility/community policy.
- Use of the original form is strongly encouraged. Photocopies and faxes of signed MOST forms are legal and valid.

Using MOST

- A person with capacity, or the Healthcare Decision Maker of a person without capacity, can request alternative treatment.

Reviewing MOST

It is recommended that the MOST be reviewed periodically. Review is recommended when

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.