DELAWARE MEDICAL ORDERS FOR SCOPE OF TREATMENT (DMOST)

- FIRST, follow the orders below. THEN contact physician or other health-care practitioner for further orders, if indicated.
- The DMOST form is voluntary and is to be used by a patient with serious illness or frailty whose health care practitioner would not be surprised if the patient died within next year.
- Any section not completed requires providing the patient with the full treatment described in that section.
- Always provide comfort measures, regardless of the level of treatment chosen.
- The Patient or the Authorized Representative has been given a plain-language explanation of the DMOST form.
- The DMOST form must accompany the patient at all times. It is valid in every health care setting in Delaware.

_____ / / _____ _____

Print Patient's Name (last, first, middle) Date of Birth last four digits of SSN Gender

_____ _____

Patient's Address Phone Number

A **Goals of Care** (see reverse for instructions. This section does not constitute a medical order.)

B **Cardiopulmonary Resuscitation (CPR)** *Patient has no pulse and/or is not breathing*

☐ Attempt resuscitation/CPR. ☐ Do not attempt resuscitation/DNAR.

C **Medical Interventions:** *Patient is breathing and/or has a pulse.*

☐ **Full Treatment**: Use all appropriate medical and surgical interventions, including intubation and mechanical ventilation in an intensive care setting, if indicated to support life. Transfer to a hospital, if necessary.

☐ **Limited Treatment**: Use appropriate medical treatment, such as antibiotics and IV fluids, as indicated. May use oxygen and noninvasive positive airway pressure. Generally avoid intensive care.

- ☐ Transfer to hospital for medical interventions.
- ☐ Transfer to hospital only if comfort needs cannot be met in current setting.

☐ **Treatment of Symptoms Only/Comfort Measures:** Use any medications, including pain medication, by any route, positioning, wound care, and other measures to keep clean, warm, dry, and comfortable. Use oxygen, suctioning, and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

☐ **Other Orders**:_____

D **Artificially Administered Fluids and Nutrition:** *Always offer food/fluids by mouth if feasible and desired.*

☐ Long-term artificial nutrition

☐ Defined trial period of artificial nutrition: Length of trial: _____Goal:_____

☐ No artificial nutrition ☐ hydration only ☐ none (check one box)

E **Orders Discussed With:** ☐ Patient _____ph.#_____

Printed Name & phone number

☐ Guardian ☐ Surrogate (per DE Surrogacy Statute)

☐ Other ☐ Agent under healthcare POA/or AHCD _____

Signature

☐ Parent of a minor

_____

Print Name of Authorized Representative Relation to Patient Address Phone #

If I lose capacity, my Authorized Representative may / may not change or void this DMOST _____

Patient Signature

F **SIGNATURES:** Patient/Authorized Representative/Parent (mandatory) *I have discussed this information with my Physician / APRN / PA*

_____

Signature Date

If authorized representative signs, the medical record must document that a physician has determined the patient's incapacity & the authorized representative's authority, in accordance with DE law.

Physician / APRN / PA

_____

Signature Date Time

_____

Print Name

_____

Print Address

_____

License Number Phone #

DIRECTIONS FOR HEALTH-CARE PROFESSIONALS

COMPLETING A DMOST FORM

- Must be signed by a Licensed Physician, Advance Practice Registered Nurse, or Physician's Assistant.
- Use of original form is highly encouraged. Photocopies and faxes of signed DMOST forms are legal and valid.
- Any incomplete section of a DMOST form indicates the patient should get the full treatment described in that section.

REVIEWING A DMOST FORM -- It is recommended that a DMOST form be reviewed periodically, especially when:

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

MODIFYING AND VOIDING INFORMATION ON A COMPLETED DMOST FORM

A patient with decision-making capacity can void a DMOST form at any time in any manner that indicates an intent to void.

Any modification to the form voids the DMOST form. A new DMOST form may be completed with a health care practitioner. Forms are available online at www.delaware.gov/.

SECTION A This section outlines the specific goals that the patient is trying to achieve by this treatment plan. Health care professionals shall share information regarding prognosis with the patient in order to assist the patient in setting achievable goals. Examples may include:

- Longevity, cure, remission or better quality of life
- To live long enough to attend an important event (wedding, birthday, graduation)
- To live without pain, nausea, shortness of breath or other symptoms
- Eating, driving, gardening, enjoying time with family, or other activities

SECTION B This is a medical order. Mark a selection for the patient's preferences regarding CPR.

SECTION C This is a medical order. When "limited treatment" is selected, also indicate whether the patient prefers or does not prefer transfer to a hospital for additional care.

- IV medication to enhance comfort may be appropriate treatment for a patient who has indicated "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP).
- The patient will always be provided with comfort measures.
- Patients who are already receiving long-term mechanical ventilation may indicate treatment limitations on the "Other Orders" line.

SECTION D This is medical order. Mark a selection for the patient's preferences regarding nutrition and hydration. Check one box.

- Oral fluids and nutrition should always be offered if feasible and consistent with the goals of care.

SECTION E This section documents with whom the medical orders were discussed, the name of any healthcare professional who assisted in the completion of the Form, the name of any authorized representative and if the authorized representative may not modify/void the Form.

SECTION F To be valid, all information in this section must be completed.

HIPAA PERMITS DISCLOSURE OF DMOST FORMS TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT.

SEND FORM WITH PATIENT WHENEVER MOVED TO A NEW SETTING

Faxed, Copied, or Electronic Versions of the Form are legal and valid.