DMOST

Delaware Medical Orders For Scope Of Treatment

CHECKLIST

Complete each step as appropriate and document with checkmark to support DMOST as valid and enforceable.

1) ❐ ____________________ /____/____________________

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

2) ONLY for Patients with Developmental Disabilities (DD)

❐ Identified appropriate Authorized Representative (AR) ____________________
(print name)

Role in regard to patient with DD ____________________
(type role here)

3) ❐ Patient verification by **two (2) unique identifiers** *(i.e. driver's license, hospital record/hospital bracelet, etc.)*

4) ❐ Confirm patient appropriate for DMOST by review of medical record or facts as known

Diagnosis ____________________

Prognosis ____________________

❐ *(The health-care practitioner would not be surprised if patient died within next year.)*

5) Does the patient have a Advance Health-Care Directive? ❐ Yes ❐ No

6) If Yes, who is the AR? ____________________
(print name)

7) Is that agent still the patient's chosen representative? ❐ Yes ❐ No

8) If No, why? ____________________ Who is the current choice? ____________________

9) ❐ Authenticate patient's signature *or*, signature of 2 persons: health-care provider __________ and other __________
(print name) *(print name)*

10) ❐ Capacity as determined by the physician noted here: ____________________
(print physician name)

❐ Patient with capacity ❐ Patient without capacity

11) ❐ Where form completed: ❐ Hospital ❐ Long-Term Care facility ❐ Home ❐ Other

Print location name ____________________

12) ❐ Reviewed goals of care and plain language FAQ with patient and/or AR.

13) ❐ For each section of the form, have reviewed medical treatments/procedures with patient and/or AR in terms of risks/benefits and expected outcomes with and without such treatments/procedures.

14) ❐ All mandatory signatures have been obtained.

15) ❐ Medical criteria to consider withdrawal/withhold life-sustaining treatment (LST):

❐ Terminal illness ❐ Permanently unconscious ❐ Medical condition (other than DD) that is irreversible and progressive

AND ❐ LST would impose undue suffering and burden

16) ❐ Notification of: ❐ AR ❐ Facility where patient lives ❐ Other

17) ❐ ____________________ ____________________

Signature of person completing this checklist *(print name)* Date Time

18) ❐ ____________________ ____________________

Countersigned practitioner *(print physician name)* Date Time