

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

MOLST

**Medical Orders for Life-Sustaining Treatment
Do-Not-Resuscitate (DNR) and
other Life-Sustaining Treatments (LST)**

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

This is a Physician's Order Sheet based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Section A is not completed, there are no restrictions for this section. When the need occurs, first follow these orders, then contact physician. Any section not completed implies full treatment for that section.

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status (improvement or deterioration), or
- The patient/resident treatment preferences change

Section

RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest):

A

Check One
Box Only

(If patient/resident has no pulse and/or no respirations)

- Do Not Resuscitate (DNR)*** [DNR = No cardiopulmonary resuscitation, endotracheal intubation or mechanical ventilation]
- Full Cardio-Pulmonary Resuscitation (CPR) – No Limitations**

* For incapacitated adults; and/or for therapeutic or medical futility exceptions; and/or for residents of OMH, OMRDD or correctional facilities, also complete relevant sections of Supplemental DNR Documentation Form for Adults. For minor patients, also complete Supplemental DNR Documentation Form for Minors. For patients in the community, also complete NYS DOH Nonhospital DNR Form, unless located in Monroe or Onondaga Counties.

Section

DNR (CPR) CONSENT OF PATIENT/RESIDENT WITH DECISION-MAKING CAPACITY:

B

Patient/
Resident/
Health Care
Agent or
Surrogate
Decision-
Maker
Consent for
Section A

Section A reflects my treatment preferences.

Patient/Resident Signature	<input type="checkbox"/> Check if verbal consent	Print Patient/Resident Name	Date
Witness of Patient/Resident Signature or Verbal Consent		Print Witness Name	Date

DNR (CPR) CONSENT OF HEALTH CARE AGENT (HCA) OR SURROGATE DECISION-MAKER FOR PATIENT / RESIDENT WITHOUT DECISION-MAKING CAPACITY:

This document reflects what is known about the patient/resident's treatment preferences. For Patient/Resident without decision-making capacity, or when medical futility or therapeutic exception is used, Supplemental MOLST Documentation Form **MUST** be completed and should always accompany this MOLST Form. If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST. Prior form attached Supplemental Documentation Form completed

Complete
one of the
subsections
of Section B

HCA/Surrogate Signature	<input type="checkbox"/> Check if verbal consent	Print Name	Date
Relationship to Patient/Resident: _____			
Witness Signature		Print Witness Name	Date

(Must witness HCA/surrogate signature or verbal/telephone consent)

Section

Physician Signature for Sections A and B:

C

Physician
Signature
for Section A
and B

Physician Signature		Print Physician Name	Date
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(Must Witness Patient/Resident Signature or Verbal Consent)

Physician License #: _____ Physician Phone/Pager #: _____

It is the responsibility of the physician to determine, within the appropriate period, (see below) whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the appropriate time period. The **physician must review these orders** as follows: **Hospital: at least every 7 Days; Nursing Home/Skilled Nursing Facility: at least every 60 Days; Nonhospital/Community Setting: at least every 90 Days**

Section

ADVANCE DIRECTIVES: Patient/Resident has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity:

D

- Health Care Proxy
- Living Will

Section E

HIPAA Permits Disclosure of MOLST to Other Health Care Professionals as necessary

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATION: (If patient/resident has pulse and/or is breathing)

This Section is "optional" depending on clinical circumstances and setting. Complete only those sub-sections that are relevant. Blank subsections can be completed at a later date. If patient has decision-making capacity, patient should be consulted prior to treatment or withholding thereof. After confirming consent of appropriate decision-maker, physician must sign and date each subsection at the time of completion.

Physician may complete form for patient with capacity or with Health Care Agent. Include Section E consent.

ADDITIONAL TREATMENT GUIDELINES: (Comfort measures are always provided.)

- Comfort Measures Only** – The patient is treated with dignity and respect. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction are used as needed for comfort. *Do Not Transfer to hospital for life-sustaining treatment. Transfer if comfort care needs cannot be met in current location.*
- Limited Medical Interventions** - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A or E. Guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below. *Transfer to the hospital as indicated.*
- No Limitations on Medical Interventions** - All indicated treatments are provided except as specified in Sections A. *Transfer to the hospital is indicated, including intensive care.*

MD Signature: _____ Date: _____

Physician may complete form for incapacitated patients without Health Care Agent only with clear and convincing evidence. Include Section E consent.

ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS: If patient/resident is DNR, and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

- Do Not Intubate (DNI)**
- A trial period of intubation and ventilation**
- Intubation and long-term mechanical ventilation, if needed**

MD Signature: _____ Date: _____

Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-B.

FUTURE HOSPITALIZATION / TRANSFER: (For long-term care residents and home patients)

- No hospitalization unless pain or severe symptoms cannot be otherwise controlled.**
- Hospitalization with restrictions outlined in Sections A and E.**

MD Signature: _____ Date: _____

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (If Health Care Agent makes decision, it must be based on knowledge of patient/resident's wishes.)

- No feeding tube** (offer food/fluids as tolerated)
- A trial period of feeding tube**
- Long-term feeding tube, if needed**
- No IV Fluids** (offer food/fluids as tolerated)
- A trial of IV fluids**

MD Signature: _____ Date: _____

ANTIBIOTICS:

- No antibiotics** (except for comfort)
- Antibiotics**

MD Signature: _____ Date: _____

OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)

MD Signature: _____ Date: _____

Section E Consent

CONSENT FOR SECTION E OF PERSON NAMED IN SECTION B: Significant thought has been given to life-sustaining treatment. Patient/resident preferences have been expressed to the physician and this document reflects those treatment preferences. As the medical decision-maker, I confirm that the orders documented above in Section E reflect patient/resident's treatment preferences.

Signature Check if verbal consent _____ Print Name _____ Date _____

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

RENEW / REVIEW INSTRUCTIONS

MOLST (DNR and Life-Sustaining Treatment)

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status (improvement or deterioration), or
- The patient/resident treatment preferences change

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

How to Complete the MOLST Form

- MOLST must be completed by a health care professional, based on patient preference and medical indications.
- MOLST must be signed by a NYS licensed physician to be valid. Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.
- If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed MOLST are legal and valid.

How to Review MOLST Form:

Step 1: Review Sections A through E

Step 2: Complete Section F below:

2a. If no changes, sign, date and check the “No Change” box.

2b. For additions to Section E “optional” directives, complete the relevant subsection(s) after securing consent from the appropriate decision-maker, sign and date subsection(s) in Section E. Then sign, date and check “Changes-Additions only” in box below.

2c. For substantive changes, (i.e. reversal of prior directive), write “VOID” in large letters on pages 1 and 2, and complete a new form. Check box marked “FORM VOIDED, new form completed”. (RETAIN voided MOLST form in chart or medical record, or as required by law.)

2d. If this form is voided and no new form is completed, full treatment and resuscitation will be provided. Write “VOID” in large letters on pages 1 and 2 and check box marked “FORM VOIDED, no new form.” (RETAIN voided MOLST form in chart or medical record, or as required by law.)

Review of this MOLST Form

Section F (Review of this Form)	Date	Reviewer’s Name and Signature	Location of Review	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form
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				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, <i>no</i> new form

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

Section F (Review of this Form)	Review of this MOLST Form (Con't from Page 3)			
	Date	Reviewer	Location of Review	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> Changes – Additions only <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
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