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)

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. Review the entire form with the patient. Any section not completed implies full treatment for that section. ***WARNING****: If patient lacks medical decision-making capacity as a result of mental retardation or developmental disability or has a legal guardian, specific, mandatory procedures need to be followed. Review information and seek legal counsel.*

Last Name/First/Middle Initial of Patient/Resident

Address

City/State/Zip

Patient/Resident Date of Birth (mm/dd/yyyy)

Gender ☐ M ☐ F

Unique Patient Identifier (Last 4 SSN)

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

SAMPLE

Section A

Check One Box Only

RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest):

(If patient/resident has no blood pressure, no pulse and no respiration) This form can be used in all settings, including community.

☐ **Do Not Resuscitate (DNR)*/Allow Natural Death** ***[DNR = No CPR, endotracheal intubation or mechanical ventilation]**

☐ **Full Cardio-Pulmonary Resuscitation (CPR)** **[No Limitations; accepts intubation and mechanical ventilation]**

* 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 residents of OMRDD without capacity in the community, also complete NYSDOH Nonhospital DNR form. For minor patients, also complete Supplemental DNR Documentation Form for Minors.

Section B

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

Complete one of the subsections of Section B

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

Section A reflects my treatment preferences.

______________________	______________________	______________
Patient/Resident Signature ☐ **Check if verbal consent ***	**Print Patient/Resident Name**	**Date**
Witness of Patient/Resident Signature or Verbal Consent	**Print Witness Name**	**Date**
Witness of Patient/Resident Signature or Verbal Consent	**Print Witness Name**	**Date**

*Patient with capacity can provide verbal consent in the presence of two adult witnesses. Written consent requires only one witness signature. If verbal consent, one witness must be a physician. In facility, physician must be affiliated with the facility, e.g. resident physician qualifies.

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 DNR form attached** ☐ **Supplemental Documentation Form completed**

______________________	______________________	______________
HCA/Surrogate Signature ☐ **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 C

Physician Signature for Section A and B

Physician Signature for Sections A and B:

______________________	______________________	______________
Physician Signature	**Print Physician Name**	**Date**

*(Must Witness Patient/Resident Signature **or** obtain Verbal Consent. Resident physician signature must be co-signed by licensed physician.)*

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 D

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

☐ **Health Care Proxy** ☐ **Living Will** ☐ **Other Written Documentation or Oral Advance Directive**

HIPAA Permits Disclosure of MOLST to Other Health Care Professionals & Electronic Registry as necessary for treatment.

Section E

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

Review patient's goals and patient's choice of interventions and then complete orders for appropriate subsections. 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, obtain signature or verbal consent and complete the consent section of Section E, at the bottom of this page.* Physician must sign and date each subsection at the time of completion.

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

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

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

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. May consider less invasive airway support (e.g. CPAP, BIPAP). *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:*

ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS:

If patient/resident chooses DNR, review all options if patient/resident has progressive or impending pulmonary failure without acute cardiopulmonary arrest. If patient chooses full CPR, review options of trial and long-term intubation & mechanical ventilation:

☐ **Do Not Intubate (DNI)**
(Review available symptomatic treatment of dyspnea: oxygen, morphine, etc.)

☐ **A trial period of intubation and ventilation** ☐ **A trial of BIPAP** ☐ **A trial of CPAP**
(Discuss duration of trial and document in other instructions.)

☐ **Intubation and long-term mechanical ventilation, if needed**

MD Signature: *Date:*

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 reasonable 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**

SAMPLE

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/First/Middle Initial of Patient/Resident
Address
City/State/Zip
Patient/Resident Date of Birth (mm/dd/yyyy)
Gender ☐ M ☐ F
Unique Patient Identifier (Last 4 SSN)

SAMPLE

How to Complete the MOLST Form

- **MOLST must be completed by a health care professional, based on patient preference and medical indications.**
- **Follow the 8-Step MOLST Protocol found at www.CompassionandSupport.org.**
- **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, FAXes and an electronic representation of the original 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 subsections(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.)

For detailed information about the MOLST Program, view www.CompassionandSupport.org.

Section F *(Review of this Form)*

Review of this MOLST Form

Date	Reviewer's Name and Signature	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
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			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form

Pages 3 & 4 contain directions and renewals only. **Continue Section F on Page 4**

Section F *(Review of this Form)*

Review of this MOLST Form *(Con't from Page 3)*

Date	Reviewer's Name & Signature	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
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SAMPLE