Review of this MOLST Form

(Con't from Page 3)

Section F *(Review of this Form)*

Date	Reviewer	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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SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

MOLST

Medical Orders for Life-Sustaining Treatment

Do-Not-Resuscitate (DNR),
Do-Not-Intubate (DNI), and
other Life-Sustaining Treatments (LST)

This is a Physician's Order Sheet. It is based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Sections A and/or B are not completed, there are no restrictions for these sections. When the need occurs, *first* follow these orders, then contact physician.

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

Section A — *Check One Box Only*

RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest):

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/DNI/LST Documentation Form for Adults. For minor patients, also complete Supplemental Documentation Form for Minors. For homebound patients, also complete NYS DOH Nonhospital DNR Form.

Section B — *Check One Box Only*

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**

Section C — *Complete Section C or Section D*

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

Sections A and B reflect 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**
Physician Signature *(Must Witness Patient/Resident Signature or Verbal Consent)*	**Print Physician Name**	**Date**

Physician Phone/Pager #: ______________________

Section D — *Complete Section C or Section D*

DNR(CPR)/DNI CONSENT OF SURROGATE DECISION-MAKER OR HEALTH CARE AGENT (HCA) 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.

Surrogate/HCA Signature ☐ **Check if verbal consent**	**Print Name**	**Date**

Relationship to Patient/Resident: ______________________

Witness Signature *(Must witness HCA/surrogate signature or verbal/telephone consent)*	**Print Witness Name**	**Date**
Physician Signature *(Must witness HCA/ surrogate signature or verbal/telephone consent)*	**Print Physician Name**	**Date**

Physician Phone/Pager #: ______________________

  This Document is Consistent with New York State Law

Section E

"OPTIONAL" ORDERS FOR OTHER LIFE-SUSTAINING THERAPIES AND FUTURE HOSPITALIZATION

This Section is "optional" depending on clinical circumstances and setting. Complete only those subsections that are relevant. Blank subsections can be completed at a later date. After confirming consent of appropriate decision-maker, physician must sign and date each subsection at the time of completion.

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.

☐ **Limited Medical Interventions** - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A, B or E. Additional guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below.

☐ **No Limitations on Medical Interventions** - All indicated treatments are provided except as specified in Sections A and B.

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, B & E.**

MD Signature: *Date:*

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:

(If decision is made by Surrogate or Health Care Agent, 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:*

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**

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:*

CONSENT FOR SECTION E OF PERSON NAMED IN SECTION C OR D:

Section E Consent

As the medical decision-maker (Patient/Resident, Surrogate Decision-maker, or Health Care Agent), I confirm that the orders documented above in Section E reflect my (the patient/resident's) treatment preferences.

Signature ☐ Check if verbal consent ______ Print Name ______ Date ______

Witness Signature *(of signature or verbal/telephone consent)* ______ Print Witness Name ______ Date ______

Physician Signature *(of signature or verbal/telephone consent)* ______ Print Physician Name ______ Date ______

Physician Phone/Pager #: ______

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

RENEW / REVIEW INSTRUCTIONS

MOLST (DNR/DNI/LST)

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

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**

How to Complete the Form Review:

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.)**

Section F

(Review of this Form)

Review of this MOLST Form

Date	Reviewer's Name and Signature	Location of Review	Outcome of Review
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Pages 3 & 4 contain directions and renewals only.

Continue Section F on Page 4