**2B:** **Medical Futility Exception:** **(required to issue a DNR/DNI order for an adult patient/resident without capacity who has no surrogate)** *We have personally examined the patient/resident and have determined with a reasonable degree of medical certainty that any attempt to perform cardiopulmonary resuscitation on this adult patient/resident would be medically futile.*

**Physician signature:** ______________________ **Print Name:** ____________________ **Date:** ___________

**Concurring physician:** ____________________ **Print Name:** ____________________ **Date:** ___________

**(Note: Unless cardiopulmonary resuscitation would be medically futile, a court order is required to issue a DNR/DNI order for a patient/resident without capacity and no surrogate. If this attestation regarding medical futility cannot be made, consult legal counsel.)**

**2C:** **Residents of OMH and OMRDD Facilities** **– Additional requirements for residents from facilities operated or licensed by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities:**

*I notified the director of the facility from which the patient/resident was transferred of:*
*a. _____ the determination that the patient/resident lacks capacity (if applicable, complete Section 1)*
*b. _____ the patient/resident's or representative's consent to a DNR/DNI order*

**Name of facility notified:** ________________________________________________

**Print name of person notified:** ____________________________________________

**Physician signature:** ______________________ **Print Name:** ____________________ **Date:** ___________

**2D:** **Residents of Correctional Facilities** **– Additional Requirements:**

*I notified the director of the correctional facility from which the patient/resident was transferred of:*
*a. _____ the determination that the patient/resident lacks capacity (if applicable, complete Section 1)*
*b. _____ the patient/resident's or representative's consent to a DNR/DNI order*

**Name of facility notified:** ________________________________________________

**Print name of person notified:** ____________________________________________

**Physician signature:** ______________________ **Print Name:** ____________________ **Date:** ___________

SECTION 2



Standard Register ®

**SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED**

# MOLST

## Medical Orders for Life-Sustaining Treatment
**(DNR/DNI/LST)**
**"Supplemental" Documentation Form for ADULTS**

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

*Complete all Sections that Apply:*
**Section 1: Adult Patients/Residents Who Lack Capacity to Consent**
**Section 2: Exceptional Circumstances**
**2A: Therapeutic Exception**
**2B: Medical Futility and No Surrogate**
**2C: Residents of OMH and OMRDD Facilities**
**2D: Residents of Correctional Facilities**

**Note: Actual orders should be placed on the MOLST form. No additional documentation beyond the MOLST form is needed for adult patients who are able to consent for themselves (when not residents of OMH, OMRDD, or Correctional Facilities.)** The physician is responsible for completing both the MOLST and this documentation form (under the circumstances outlined above), and for obtaining the additional consultations / signatures where indicated. These forms must be placed in the medical record.

## Section 1

**Complete Steps 1-9 for adult patients/residents who lack capacity to consent:**

### Step 1: Physician determination of lack of capacity:

____ **I have examined the patient/resident and his/her medical record, and have determined that the patient/resident lacks the ability to understand and appreciate the nature and consequences of a DNR/DNI order, including benefits and burdens of such an order, and to reach an informed decision regarding the order.** (Check if applicable)

Describe the cause, nature and extent of the lack of capacity: ______________________________
_____________________________________________________________

Probable duration: ______________________________________________

### Step 2: Patient/Resident notice of the determination that he or she lacks capacity:

**(Check one)**
____ a. I have not provided this notice because the patient/resident has not given any indication of the ability to comprehend his or her lack of capacity.
____ b. I have provided notice about lack of capacity directly to the patient/resident.

### Step 3: Physician determination of lack of utility for cardiopulmonary resuscitation:

**I have examined the patient/resident and his/her medical record, and have determined to a reasonable degree of medical certainty that:** (Check all that apply)
____ a. The patient/resident has a terminal condition
____ b. The patient/resident is permanently unconscious
____ c. Resuscitation would be medically futile
____ d. Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident's medical condition and the expected outcome of resuscitation

SECTION 1

 **©2003 Rochester Health Commission** **This Document is Consistent with New York State Law**

**Step 4: Surrogate Selection:** The physician must determine who is the proper surrogate for the purposes of helping with medical decisions for the patient/resident who lacks capacity, including DNR/DNI decisions and other treatments covered in the MOLST Form. For a DNR/DNI decision, the surrogate must be selected from the following list in order of priority: (please check which one is selected)

____ 1. Patient/resident's designated health care agent
____ 2. Court-appointed committee or guardian of the patient/resident
____ 3. Patient/resident's spouse
____ 4. Patient/resident's son or daughter, age 18 or older
____ 5. Patient/resident's parent
____ 6. Patient/resident's brother or sister, age 18 or older
____ 7. Patient/resident's close friend, age 18 or older (affidavit of close friend required; see below)
____ 8. No appropriate surrogate decision-maker is available (go to Section **2B**: Medical Futility)

**Print name of designated surrogate:** ____________________

**Relationship to patient/resident:** ____________________

**Step 5: Surrogate consent:** *As the surrogate decision-maker for ____________ (patient/resident name), I authorize Dr. ____________ to write DNR/DNI order on the MOLST form. I understand that this means that cardiopulmonary resuscitation will be withheld if his/her heart stops beating or he/she stops breathing. I have also reviewed and consent on the patient/resident's behalf to any other limitations on medical intervention designated on the MOLST form.*

**Surrogate signature:** ____________________ **Date:** __________

☐ **Check if verbal consent**

*I certify that the person whose signature appears above signed and dated this form in my presence.*

**Witness signature:** ____________________ **Date:** __________

**Print witness name:** ____________________

**Step 6: Patient/resident notice of the determination that surrogate has signed a DNR/DNI order on the patient/resident's behalf (please check one):**

____ a. I have not provided notice because the patient/resident has not given any indication of the ability to comprehend this DNR/DNI decision.
____ b. I have not provided notice because the patient/resident would suffer immediate and severe injury from a DNR/DNI discussion.
____ c. Neither a or b above apply, so I have provided notice that a surrogate has authorized a DNR/DNI decision directly to the patient/resident.

**Step 7: Affidavit of close friend (applies only if a close friend is selected as surrogate, otherwise skip)**

*I, ____________________, hereby state under penalty of perjury that I am a close friend of ____________________ (the patient/resident), have maintained regular contact with the patient/resident, and am familiar with the patient/resident's activities, health, and religious or moral beliefs. I am familiar with these matters regarding the patient/resident as a result of:*

____________________

____________________

**Signature of Close Friend:** ____________ **Print name:** ____________

**Sworn before me this** ______ **day of** ____________ , ______ .

**Notary Public:** ____________________ **Stamp:** ____________

SECTION 1





# MOLST

## Medical Orders for Life-Sustaining Treatment (DNR/DNI/LST)

## "Supplemental" Documentation Form for ADULTS

*(continued)*

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

SECTION 1

**Step 8: Physician certification and signature:**

I certify that I have examined the patient/resident and his/her medical record, and that I have reviewed and completed **Steps 1-6** on this document, supporting my writing a do-not-resuscitate order and other treatment limitations on the MOLST form in this patient/resident's medical record.

Physician Signature ____________ Print Name ____________ Date ____________

**Step 9: Concurring physician certification and signature:**

I certify that I have examined the patient/resident and his/her medical record, and I have reviewed **Steps 1 and 3** in this form (determination of lack of decision-making capacity and certification of lack of utility of cardio-pulmonary resuscitation), supporting, with a reasonable degree of medical certainty, the physician writing a do-not-resuscitate order and other treatment limitations on the MOLST form in this patient/resident's medical record.

Concurring Physician Signature ____________ Print Name ____________ Date ____________

# Section 2: Exceptional Circumstances

**(Note: Complete each section only if it applies)**

**2A: Therapeutic Exception***
**2B: Medical Futility and No Surrogate***
**2C: Residents of OMH and OMRDD Facilities***
**2D: Residents of Correctional Facilities***

*** Under these exceptional circumstances, please send Supplemental MOLST Documentation Form along with MOLST Physician Order Form when patient/resident is changing facilities.**

SECTION 2

**2A: Therapeutic Exception (for patient/resident with capacity who would suffer immediate and severe harm by a discussion about DNR/DNI):**

Three conditions must apply when invoking the therapeutic exception:
i) State the reasons why harm would result from informing the patient/resident
ii) Make every effort to ascertain the patient/resident's wishes and values about DNR/DNI
iii) Obtain consent from surrogate according to Section I - Step 5 above.

State reasons for invoking the therapeutic exception: ____________________

____________________

____________________

***I have personally examined the patient/resident, and have determined to a reasonable degree of medical certainty that the patient/resident would suffer immediate and severe harm from discussion of DNR/DNI.***

**Physician signature:** ____________________ **Date:** __________

**Print name:** ____________________

**Concurring physician signature:** ____________________ **Date:** __________

**Print name:** ____________________