MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT



Patient's Name
Date of Birth
Medical Record Number if applicable:

(MOLST) www.molst-ma.org

INSTRUCTIONS: Every patient should receive full attention to comfort.

- → This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the patient's clinician.
- → Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- → If a section is not completed, there is no limitation on the treatment indicated in that section.
- → The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

The form is effective infinediately upon signature. Photocopy, tax of efectionic copies of property signed words from a re-valid.				
А	CARDIOPULMONARY RESUSCITATION: for a patient in cardiac	or respiratory arrest		
Select one circle →	O Do Not Resuscitate	O Attempt Resuscitation		
В	VENTILATION: for a patient in respiratory distress	•		
Select one circle →	O Do Not Intubate and Ventilate	O rubate and Ventilate		
Select one circle →	O Do Not Use Non-invasive Ventilation (e.g. CPAP)	Ve Non-invasive Ventilation (e.g. CPAP)		
С	TRANSFER TO HOSPITAL			
Select one circle →	O Do Not Transfer to Hospital (unless needed for gunfort)	Transfer to Hospital		
PATIENT or patient's representative signature	Select one circle below to indicate who is signing section D: o Patient o Health Care of o Suardian* Signature of patient confirms this form was sened a latient's own free will are expressed to the Section E sign of signature by the patient's representative (in the patient's representative).			
D Required Select circle and fill in every line	his/her assessment of the patient's wish and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. *A guard. *r \(can sight to the extent permitted by MA law. Consult legal counsel with questions about guardian's a knority.			
for valid orders	Signature of Patient (or Person epresenting the Patient)	Date of Signature		
	Legible Printed Name of Signer	Telephone Number of Signer		
CLINICIAN signature	Signature of physician, nurse practitioner or physician assistant confirms that with the signer in Section D.	this form accurately reflects his/her discussion(s)		
E Required	Signature of Physician, Nurse Practitioner, or Physician Assistant	Date of Signature		
Fill in every line for valid orders	Legible Printed Name of Signer	Telephone Number of Signer		
Optional	This form does not expire unless expressly stated. Expiration date (if			
Expiration date and other patient care	Health Care Agent Printed NamePrimary Care Provider Printed Name			
contacts	Tilliary Care Floviuci Fillicu Ivallie			
SEND THIS FORM WITH THE PATIENT AT ALL TIMES.				

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

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F	Statement of Patient Preferences for Other Medically-Indicated Treatments			
-	INTUBATION AND VENTILATION			
	O Refer to Section B on	O Use intubation and ventilation as checked	O Undecided	
Select one circle →	Page 1	in Section B, but short term only	O Did not discuss	
	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
Select one circle →	O Refer to Section B on	O Use non-invasive ventilation as checked	O Undecided	
	Page 1	in Section B, but short term only	O Did not discuss	
	DIALYSIS			
Select one circle →	O No dialysis	O Use dialysis	O Undecided	
20.000 0.10 0.10 2		O Use dialysis, but short term only	O Did not discuss	
	ARTIFICIAL NUTRITION			
Select one circle →	O No artificial nutrition	O Use artificial nutrition	O Undecided	
		O Use artificial nutrition, but short termenly	O Did not discuss	
	ARTIFICIAL HYDRATION			
Select one circle →	O No artificial hydration	O Use artificial hydration	Undecided	
		O Use artificial hydration, but short term ply	O Did not discuss	
	Other treatment preferences specific to the patient's medical andition and care			
PATIENT	Select one circle below to	indicate where sight of Section G:		
or patient's representative	o Patient o Healt	th Care Agent o Guardian* o Pa	arent/Guardian* of minor	
signature	Signature of patient confirms this	s form was signed a patient's own free will and refle	cts his/her wishes and goals of care as	
	expressed to the Section H sign	s form we say to patient's own free will and refle er. Signature by the patient's representative (indicate	ed above) confirms that this form reflects	
G	his/her assessment of the patients shes and gals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. *A gual ian control to the extent permitted by MA law. Consult legal counsel with questions			
Required	about guardian's authority.	The time of the permitted by the claim	eeneun legal eeuneel min queenene	
Select circle and fill	X			
	Ciamatura of Datio	on continuatho Dotiont)	Data of Cianatura	
in every line	Signature of Patie (or Page)	eplesenting the Patient)	Date of Signature	
	Signature of Fatter (DF Soft)			
in every line for valid orders	Legible Printed Name of Signer		Telephone Number of Signer	
in every line for valid orders CLINICIAN	Legible Printed Name of Signature of physician, nurse p	practitioner or physician assistant confirms that this	Telephone Number of Signer	
in every line for valid orders	Legible Printed Name of Signer	practitioner or physician assistant confirms that this	Telephone Number of Signer	
in every line for valid orders CLINICIAN	Legible Printed Name of Signature of physician, nurse p discussion(s) with the signer in	practitioner or physician assistant confirms that this	Telephone Number of Signer	
in every line for valid orders CLINICIAN signature	Legible Printed Name of Signature of Physician, nurse p discussion(s) with the signer in Signature of Physician, Nurse P	practitioner or physician assistant confirms that this Section G.	Telephone Number of Signer s form accurately reflects his/her Date of Signature	
in every line for valid orders CLINICIAN signature H Required Fill in every line for	Legible Printed Name of Signature of physician, nurse p discussion(s) with the signer in	practitioner or physician assistant confirms that this Section G.	Telephone Number of Signer s form accurately reflects his/her	
in every line for valid orders CLINICIAN signature H Required	Legible Printed Name of Signer Signature of physician, nurse p discussion(s) with the signer in Signature of Physician, Nurse P Legible Printed Name of Signer	practitioner or physician assistant confirms that this Section G.	Telephone Number of Signer s form accurately reflects his/her Date of Signature Telephone Number of Signer	

Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable____

- → Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided.
- Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.
- → The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment.

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