MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org

Patient's Name ______________________________

Date of Birth ______________________________

Medical Record Number if applicable: ____________

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.

A — Select one circle →

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

O Do Not Resuscitate   O Attempt Resuscitation

B — Select one circle →

VENTILATION: for a patient in respiratory distress

O Do Not Intubate and Ventilate   O Intubate and Ventilate

Select one circle →

O Do Not Use Non-invasive Ventilation (e.g. CPAP)   O Use Non-invasive Ventilation (e.g. CPAP)

C — Select one circle →

TRANSFER TO HOSPITAL

O Do Not Transfer to Hospital (*unless needed for comfort*)   O Transfer to Hospital

D — PATIENT or patient's representative signature

Required — Select circle and fill in every line for valid orders

Select one circle below to indicate who is signing Section D:

o Patient   o Health Care Agent   o Guardian*   o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign to the extent permitted by MA law. Consult legal counsel with questions about guardian's authority.*

✗ ______________________________   ______________________________

Signature of Patient (or Person Representing the Patient)   Date of Signature

______________________________   ______________________________

Legible Printed Name of Signer   Telephone Number of Signer

E — CLINICIAN signature

Required — Fill in every line for valid orders

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

✗ ______________________________   ______________________________

Signature of Physician, Nurse Practitioner, or Physician Assistant   Date of Signature

______________________________   ______________________________

Legible Printed Name of Signer   Telephone Number of Signer

Optional — Expiration date and other patient care contacts

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* ____________________

Health Care Agent Printed Name ______________________________ Telephone Number ______________

Primary Care Provider Printed Name ______________________________ Telephone Number ______________

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.

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

F — Statement of Patient Preferences for Other Medically-Indicated Treatments

INTUBATION AND VENTILATION

Select one circle →

O Refer to Section B on Page 1	O Use intubation and ventilation as checked in Section B, but short term only	O Undecided O Did not discuss

NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)

Select one circle →

O Refer to Section B on Page 1	O Use non-invasive ventilation as checked in Section B, but short term only	O Undecided O Did not discuss

DIALYSIS

Select one circle →

O No dialysis	O Use dialysis O Use dialysis, but short term only	O Undecided O Did not discuss

ARTIFICIAL NUTRITION

Select one circle →

O No artificial nutrition	O Use artificial nutrition O Use artificial nutrition, but short term only	O Undecided O Did not discuss

ARTIFICIAL HYDRATION

Select one circle →

O No artificial hydration	O Use artificial hydration O Use artificial hydration, but short term only	O Undecided O Did not discuss

Other treatment preferences specific to the patient's medical condition and care ______________________________

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G — PATIENT or patient's representative signature

Required

Select circle and fill in every line for valid orders

Select one circle below to indicate who is signing Section G:

o Patient   o Health Care Agent   o Guardian*   o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign to the extent permitted by MA law. Consult legal counsel with questions about guardian's authority.*

✗ ______________________________________ ______________________

Signature of Patient (or Person Representing the Patient) | Date of Signature

______________________________________ ______________________

Legible Printed Name of Signer | Telephone Number of Signer

H — CLINICIAN signature

Required

Fill in every line for valid orders

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.

✗ ______________________________________ ______________________

Signature of Physician, Nurse Practitioner, or Physician Assistant | Date of Signature

______________________________________ ______________________

Legible Printed Name of Signer | Telephone Number of Signer

Additional Instructions For Health Care Professionals

→ 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.