Medical Orders for Life-Sustaining Treatment (MOLST) MODEL Ohio Form - Page 1 of 2

Patient Name (Print): _____ **Date of Birth:** _____

These medical orders are based on the person's current medical condition and advance directive/preferences. Any section not completed does not invalidate the form and implies full treatment for that section. Use of this form is an option of the healthcare facility. This form is not transferrable from one site of care to another.

Section A	**CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**
Check only one	☐ **Attempt Resuscitation/CPR.** With **full treatment and intervention** including intubation, advanced airway interventions, mechanical ventilation, defibrillation, and cardioversion as indicated. *Transfer to intensive care if indicated.* ☐ **Do NOT Attempt Resuscitation/DNR No CPR**

When not in cardiopulmonary arrest, follow orders in Sections B, C and D.

Section B	**MEDICAL INTERVENTIONS: Person has a pulse and/<u>or</u> is breathing.**
Check only one	☐ **Full Intervention.** Includes care described below in this section. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to intensive care if indicated.* *Additional Orders/Instructions:*_____ ☐ **Limited Additional Interventions.** Includes care described below in this section. Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider airway support (e.g., CPAP, BiPAP). *Avoid intensive care.* *Additional Orders/Instructions:*_____ ☐ **Comfort Measures Only**. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Do not transfer to higher level of care for life-sustaining treatment.* *Additional Orders/Instructions:*_____
Section C	**ANTIBIOTICS**
Check only one	☐ Use antibiotics if medically indicated. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ No antibiotics. Use other measures to relieve symptoms. *Additional Orders/Instructions:*_____
Section D	**ARTIFICIALLY / MEDICALLY-ADMINISTERED NUTRITION / HYDRATION: Always offer by mouth, if feasible.**
Check only one in each column	☐ Long-term artificial nutrition by tube ☐ Artificial nutrition by tube for a defined trial period ☐ No artificial nutrition by tube ☐ Long-term IV fluids, if indicated ☐ IV fluids for a defined trial period ☐ No IV fluids *Additional Orders/Instructions:*_____

Turn Over →

Section E BASIS FOR ORDERS & SIGNATURES

My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by the advance directive and/or previous or recent discussions with:

- ☐ Patient*
- ☐ Living Will – Attach copy
- ☐ Ohio DNR Identification Form – Attach copy
- ☐ DPoA-HC Agent* – Attach copy
- ☐ Next of Kin/Surrogate as designated by Ohio law*
- ☐ Parent of Minor*
- ☐ Court-Appointed Guardian*
- ☐ Other: _____

If I lose decision-making capacity, I authorize my medical power of attorney representative, agent, attorney-in-fact to make all medical decisions for me, including those regarding CPR and other life-sustaining treatment and to complete a new form. I acknowledge that instructions in this form may be inconsistent with prior instructions in my durable power of attorney for healthcare.

☐ Initials in this box indicate patient acceptance of this statement.

*Name (print): _____ *Phone Contact: _____

*Signature (mandatory): _____ *Date Signed: _____

Name of Physician/APRN/PA (print)	Signature of Physician/APRN/PA	Date Signed

REVIEW OF MOLST

This form must be reviewed if there is substantial change in patient/resident health status, if the patient/resident treatment preferences change, or if the patient/resident is transferred from one health care setting to another.

NOTE: If person has a DNR-CC or DNR-CC Arrest Order, a completed, official Ohio DNR Identification Form MUST be attached to this document whenever the person is transferred from one site of care to another.
