NEW YORK HEALTH CARE PROXY
PAGE 1 OF 6

PART I

Part I. Health Care Proxy

PRINT YOUR NAME

I, _____, hereby appoint:
(name)

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

_____
(name, home address and telephone number of agent)

_____

as my health care agent.

In the event that the person I name above is unable, unwilling, or reasonably unavailable to act as my agent, I hereby appoint

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____
(name, home address and telephone number of agent)

_____

as my health care agent.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

My agent has the authority to make any and all health care decisions for me, except to the extent that I state otherwise here:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

_____
_____
_____
_____
_____
_____

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

SPECIFY THE DATE OR CONDITIONS FOR EXPIRATION, IF ANY

_____
_____
_____

When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

My agent should also consider the following instructions when making health care decisions for me:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(Attach additional pages if needed)

PART II

This Living Will has been prepared to conform to the law in the State of New York, and is intended to be "clear and convincing" evidence of my wishes regarding the health care decisions I have indicated below.

PRINT YOUR NAME

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to regarding health care under the circumstances indicated below:

LIFE-SUSTAINING TREATMENTS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (**Initial only one box**)

INITIAL ONLY ONE CHOICE: (a) OR (b)

[ ] (a) **Choice NOT To Prolong Life**

IF YOU DO NOT AGREE WITH EITHER CHOICE, YOU MAY WRITE YOUR OWN DIRECTIONS ON THE NEXT PAGE

I do not want my life to be prolonged if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

IF YOU INITIAL BOX (a), YOU MAY INITIAL SPECIFIC TREATMENTS YOU WOULD LIKE WITHHELD

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want artificial nutrition and hydration.
I do not want antibiotics.

OR

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF

_____
_____
_____
_____

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

_____
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These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

My agent, if I have appointed one in Part I or elsewhere, has full authority to resolve any question regarding my health care decisions, as recorded in this document or otherwise, and what my choices may be.

ORGAN DONATION (OPTIONAL)

INITIAL THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

INITIAL ONLY ONE

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

OPTIONAL ORGAN DONATION:

Upon my death: (initial only one applicable box)

[ ] (a) I do not give any of my organs, tissues, or parts and do not want my agent, guardian, or family to make a donation on my behalf;

[ ] (b) I give any needed organs, tissues, or parts;

OR

[ ] (c) I give the following organs, tissues, or parts only:

_____
_____
_____

My gift, if I have made one, is for the following purposes: (initial any of the following you **do not** want)

[ ] - Transplant
[ ] - Therapy
[ ] - Research
[ ] - Education

PART III

SIGN AND DATE
THE DOCUMENT
AND PRINT YOUR NAME
AND
ADDRESS

WITNESSING
PROCEDURE

YOUR
WITNESSES
MUST SIGN AND DATE
AND
PRINT THEIR NAMES AND
ADDRESSES HERE

Part III. Execution

Signed _____Date_____

Print Name_____

Address _____

_____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Signed _____Date_____

Print Name_____

Address _____

_____

Witness 2

Signed _____Date_____

Print Name_____

Address _____

_____

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

eMOLST NUMBER **(THIS IS NOT AN eMOLST FORM)**

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT _____ DATE OF BIRTH (MM/DD/YYYY) _____

SECTION E — Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.

☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.

☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should ***not*** be checked if full CPR is checked in Section A.)

☐ **A trial period** *Check one or both:*

- ☐ **Intubation and mechanical ventilation**
- ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**

☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**

☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. *Check one each for feeding tube and IV fluids:*

☐ **No feeding tube** ☐ **No IV fluids**

☐ **A trial period of feeding tube** ☐ **A trial period of IV fluids**

☐ **Long-term feeding tube, if needed**

Antibiotics *Check one:*

☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.

☐ **Determine use or limitation of antibiotics when infection occurs.**

☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, etc.).

_____

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

SIGNATURE _____ ☐ Check if verbal consent (Leave signature line blank) DATE/TIME _____

PRINT NAME OF DECISION-MAKER _____

PRINT FIRST WITNESS NAME _____ PRINT SECOND WITNESS NAME _____

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes
☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

Physician Signature for Section E

PHYSICIAN SIGNATURE _____ PRINT PHYSICIAN NAME _____ DATE/TIME _____

This MOLST form has been approved by the NYSDOH for use in all settings.

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on This MOLST Form

The physician must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT ____________________ DATE OF BIRTH (MM/DD/YYYY) ____________

SECTION F Review and Renewal of MOLST Orders on This MOLST Form *Continued from Page 3*

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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