

**NEW YORK ATTORNEY GENERAL - ADVANCE DIRECTIVE  
(MEDICAL POA, LIVING WILL, MOLST)**

(1) I, \_\_\_\_\_

hereby appoint

\_\_\_\_\_

(name, home address and telephone number)

\_\_\_\_\_

\_\_\_\_\_

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

\_\_\_\_\_

(name, home address and telephone number)

\_\_\_\_\_

\_\_\_\_\_

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

\_\_\_\_\_

\_\_\_\_\_

- (4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

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In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) **Your Identification (please print)**

Your Name \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Your Address \_\_\_\_\_

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

Any needed organs and/or tissues

The following organs and/or tissues \_\_\_\_\_

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Limitations \_\_\_\_\_

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

(7) **Statement by Witnesses** (*Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.*)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____	Date _____
Name of Witness 1 (print) _____	Name of Witness 2 (print) _____
Signature _____	Signature _____
Address _____ _____	Address _____ _____

**NEW YORK  
LIVING WILL – PAGE 1 OF 4**

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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.

**NEW YORK  
LIVING WILL – PAGE 2 OF 4**

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**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:

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**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:

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

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

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

**NEW YORK  
LIVING WILL – PAGE 3 of 4**

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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:

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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

**NEW YORK  
LIVING WILL – PAGE 4 of 4**

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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 \_\_\_\_\_  
\_\_\_\_\_

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 [checkbox] 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? [checkbox] Patient [checkbox] Health Care Agent [checkbox] Public Health Law Surrogate [checkbox] Minor's Parent/Guardian [checkbox] §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:

- [checkbox] Health Care Proxy [checkbox] Living Will [checkbox] Organ Donation [checkbox] Documentation of Oral Advance Directive



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

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
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
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			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form

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
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <b>no</b> new form
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