

**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 signing 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 any 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.

<p>A</p> <p>Mark one circle →</p>	<p>CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest</p> <p><input type="radio"/> Do Not Resuscitate <input type="radio"/> Attempt Resuscitation</p>
<p>B</p> <p>Mark one circle →</p> <p>Mark one circle →</p>	<p>VENTILATION: for a patient in respiratory distress</p> <p><input type="radio"/> Do Not Intubate and Ventilate <input type="radio"/> Intubate and Ventilate</p> <hr style="border-top: 1px dashed black;"/> <p><input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP) <input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)</p>
<p>C</p> <p>Mark one circle →</p>	<p>TRANSFER TO HOSPITAL</p> <p><input type="radio"/> Do Not Transfer to Hospital (<i>unless needed for comfort</i>) <input type="radio"/> Transfer to Hospital</p>
<p>PATIENT or patient's representative signature</p> <p>D</p> <p><i>Required</i></p> <p>Mark one circle and fill in every line for valid Page 1.</p>	<p>Mark one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor</p> <p>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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i></p> <p><input checked="" type="radio"/> _____ Signature of Patient (or Person Representing the Patient) _____ Date of Signature</p> <p>_____ _____ Legible Printed Name of Signer Telephone Number of Signer</p>
<p>CLINICIAN signature</p> <p>E</p> <p><i>Required</i></p> <p>Fill in every line for valid Page 1.</p>	<p>Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.</p> <p><input checked="" type="radio"/> _____ Signature of Physician, Nurse Practitioner, or Physician Assistant _____ Date and Time of Signature</p> <p>_____ _____ Legible Printed Name of Signer Telephone Number of Signer</p>
<p>Optional</p> <p>Expiration date (if any) and other information</p>	<p>This form does not expire unless expressly stated. <i>Expiration date (if any) of this form:</i> _____</p> <p>Health Care Agent Printed Name _____ Telephone Number _____</p> <p>Primary Care Provider Printed Name _____ Telephone Number _____</p>

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

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

F	Statement of Patient Preferences for Other Medically-Indicated Treatments		
	INTUBATION AND VENTILATION		
Mark one circle →	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use intubation and ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
G	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)		
	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use non-invasive ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
H	DIALYSIS		
	<input type="radio"/> No dialysis	<input type="radio"/> Use dialysis <input type="radio"/> Use dialysis, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
I	ARTIFICIAL NUTRITION		
	<input type="radio"/> No artificial nutrition	<input type="radio"/> Use artificial nutrition <input type="radio"/> Use artificial nutrition, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
J	ARTIFICIAL HYDRATION		
	<input type="radio"/> No artificial hydration	<input type="radio"/> Use artificial hydration <input type="radio"/> Use artificial hydration, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Other treatment preferences specific to the patient's medical condition and care _____			

PATIENT or patient's representative signature G <i>Required</i>	Mark one circle below to indicate who is signing Section G:		
	<input type="radio"/> Patient	<input type="radio"/> Health Care Agent	<input type="radio"/> Guardian*
Mark one circle and fill in every line for valid Page 2.	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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i>		
	_____ Signature of Patient (or Person Representing the Patient)		_____ Date of Signature
	_____ Legible Printed Name of Signer		_____ Telephone Number of Signer

CLINICIAN signature H <i>Required</i> Fill in every line for valid Page 2.	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 and Time 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. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*