

HEALTH CARE PROXY

(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)*:

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, Eye and/or Tissue Donation

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

Any needed organs, eyes and/or tissues

The following organs, eyes and/or tissues _____

Limitations _____

If you do not state your wishes or instructions about organ, eye 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.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____



New York State Living Will

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case In re Westchester County Medical Center, 72 N.Y. 2d 517 (1988). In that case the Court established the need for “clear and convincing” evidence of a patient’s wishes and stated that the “ideal situation is one in which the patient’s wishes were expressed in some form of writing, perhaps a ‘Living Will’.”

I, [1] _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, 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.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. 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:**

[2]

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.

However, I **do want** maximum pain relief, even if it may hasten my death.

[3] Other directions:

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.

[4]

Signed _____ Date _____

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.

[5]

Name of Witness 1 (please print, sign and date)

Signed _____ Date _____

Address _____

Name of Witness 2

Signed _____ Date _____

Address _____

This is a medical order form for life-sustaining treatment. A health care professional must complete the MOLST form based on the patient's current medical condition, values, and wishes. 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. The health care practitioner issuing the medical orders 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 health care practitioner examines the patient, reviews the orders, and voids this form. General Instructions for completing the MOLST are found on page 4 of this document.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician, nurse practitioner, or physician assistant who will issue the orders and consider asking them 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 an intellectual or developmental disability (I/DD) and lacks the capacity to decide, a physician (not a nurse practitioner or physician assistant) must issue the orders. The physician must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. An asterisk (*) on this form means:

*If this decision relates to an adult or minor patient with an intellectual or developmental disability (I/DD), refer to the instructions on page 4 before proceeding.

Do-Not-Resuscitate (DNR) and Do-Not-Intubate (DNI) Medical Orders

Section A Patient Information

LAST NAME/FIRST NAME/MIDDLE INITIAL

ADDRESS/CITY/STATE/ZIP

PREFERRED PHONE NUMBER

DATE OF BIRTH (MM/DD/YYYY)

eMOLST NUMBER, if applicable. This is not an eMOLST form.

CHECK ALL ADVANCE DIRECTIVES KNOWN TO BE COMPLETED:

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

Section B Resuscitation Orders When the Patient Has No Pulse and/or Is Not Breathing

CHECK ONE:

- CPR ORDER: ATTEMPT CARDIOPULMONARY RESUSCITATION
- DNR ORDER: DO NOT ATTEMPT RESUSCITATION (ALLOW NATURAL DEATH)

Section C Intubation Orders for Life-Sustaining Treatment When the Patient Has a Pulse and is Breathing

RESPIRATORY SUPPORT: NON-INVASIVE VENTILATION and/or INTUBATION AND MECHANICAL VENTILATION

CHECK ONE:

- Intubation and long-term mechanical ventilation, may include tracheostomy
- A trial period of intubation and/or mechanical ventilation*
- Do Not Intubate (DNI); Use of non-invasive ventilation only
- Do Not Intubate (DNI) and Do Not Use non-invasive ventilation or mechanical ventilation

Section D Consent for Sections B and C

Signature of Individual Making Decisions

Printed Name of Individual Making Decisions

- For verbal consent only, leave signature line blank

Date/Time of Consent:

- Written consent, sign above

Who is the individual making decisions:

- Patient
- Health Care Agent
- FHCDA Surrogate for adult
- FHCDA Surrogate for minor
- §1750-b Surrogate for adult or minor with I/DD

Printed Name of First Witness*

Printed Name of Second Witness

Section E Physician, Nurse Practitioner, or Physician Assistant Signature for Sections B and C

If consent in section D was provided by a §1750-b Surrogate for an individual with an intellectual or developmental disability (I/DD), only a physician may sign this section, and only after the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD has been completed and attached.

Signature

Print Name

License Number

Date/Time

*If this decision relates to an adult or minor patient with an intellectual or developmental disability (I/DD), refer to the instructions on page 4 before proceeding.

Patient Name _____

Other Medical Orders for Life-Sustaining Treatment

Section F Additional Orders for Life-Sustaining Treatment

TREATMENT GUIDELINES (CHECK ONE)

- No limitation on medical interventions
- Limited medical interventions, only as described below
- Comfort measures only. Provide medical care and treatment with the goal of relieving pain and other symptoms

FUTURE HOSPITALIZATION/TRANSFER (CHECK ONE)

- Send to the hospital, when medically necessary
- Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled

ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION

FEEDING TUBE (CHECK ONE)

- Long-term feeding tube
- Determine use or limitation if need arises*
- No feeding tube

IV FLUIDS (CHECK ONE)

- IV fluids
- Determine use or limitation as need arises*
- No IV fluids

ANTIBIOTICS (CHECK ONE)

- Use antibiotics to treat infections
- Determine use or limitation of antibiotics when infection occurs*
- Do not use antibiotics

DIALYSIS (CHECK ONE)

- Use dialysis to treat renal failure
- Determine use or limitation if renal failure occur*
- Do not use dialysis

OTHER MEDICAL ORDERS AND INSTRUCTIONS (only as discussed with the physician, NP, or PA, may include instructions and goals for trials.* If nothing else is discussed, write NONE.)

Section G Consent for Section F

Signature of Individual Making Decisions

- For verbal consent only, leave signature line blank
- Written consent, sign above

Printed Name of Individual Making Decisions

Date/Time of Consent: _____

Who is the individual making decisions:

- Patient
- Health Care Agent
- FHCDA Surrogate for adult
- FHCDA Surrogate for minor
- §1750-b Surrogate for adult or minor with I/DD

Printed Name of First Witness*

Printed Name of Second Witness

Section H Physician, Nurse Practitioner, or Physician Assistant Signature for Section F

If consent in section G was provided by a §1750-b Surrogate for an individual with an intellectual or developmental disability, only a physician may sign this section, and only after the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD has been completed and attached.

Signature

Print Name

License Number

Date/Time

*If this decision relates to an adult or minor patient with an intellectual or developmental disability (I/DD), refer to the instructions on page 4 before proceeding.

Patient Name _____

Section I Review and Renewal

A physician, nurse practitioner, or physician assistant* must review this MOLST for appropriateness based on the patient’s medical condition at least every 90 days. The MOLST must also be reviewed 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 named in Section D changes their mind. Upon each review, the physician, nurse practitioner, or physician assistant* should indicate whether there is no change, or whether the form is voided. The attending practitioner must void the form if the patient or other decision-maker named in Section D withdraws their consent to a decision in the MOLST or if the patient objects to the decision.

Even if the MOLST is not reviewed and renewed within 90 days, the last completed MOLST remains valid and must be followed.

If the patient had capacity when the patient consented to a decision to withhold or withdraw life-sustaining treatment, a health care agent or surrogate cannot change the decision the patient has already made. If a health care agent or surrogate consented to this MOLST, a health care agent or surrogate can continue to make decisions to withhold or withdraw life-sustaining treatment based on the patient’s current health status.

Date/Time	Reviewer’s Printed Name and Signature	Location of Review	Outcome of Review
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided; new form completed <input type="checkbox"/> Form voided, no new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided; new form completed <input type="checkbox"/> Form voided, no new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided; new form completed <input type="checkbox"/> Form voided, no new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided; new form completed <input type="checkbox"/> Form voided, no new form
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			<input type="checkbox"/> No change <input type="checkbox"/> Form voided; new form completed <input type="checkbox"/> Form voided, no new form

*If this decision relates to an adult or minor patient with an intellectual or developmental disability (I/DD), refer to the instructions on page 4 before proceeding.