Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST)

www.molst-ma.org

Patient's Name

Address

Date of Birth Gender

Print name and phone # of Patient's Primary Care Provider, if available:

- ► Sections D and E must be fully completed for a valid form; photocopy, fax or electronic copies of signed MOLST forms are valid.
- ► If a section is not completed, there is no limitation on the treatment indicated in that section.
- ► This form is effective immediately upon completion. Send this form with the patient at transfer or discharge.

Every Patient Should Receive Full Attention To Comfort

A Select one box

Cardiopulmonary Resuscitation: for a patient in cardiac or respiratory arrest

☐ Do Not Resuscitate ☐ Attempt Resuscitation

B Select one box

Intubation and Ventilation: for a patient in respiratory distress

☐ Do Not Intubate and/or Ventilate ☐ Intubate and/or Ventilate

C Select one box

Transfer To Hospital

☐ Do Not Transfer to Hospital (unless needed for comfort) ☐ Transfer to Hospital

D Signature of the patient or health care agent, guardian* or parent/guardian* of a minor patient

*A guardian can sign to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.

Signed in section D by: (Check one box to indicate who is signing) ☐ the patient, or ☐ guardian* ☐ health care agent ☐ parent/guardian* of a minor

- ► If signed by patient, confirms that he/she signed of own free will and this form reflects his/her treatment preferences as expressed to Section E signer.
- ► If signed by the health care agent, guardian* or parent/guardian* of a minor patient, confirms that the form reflects the signer's assessment of the patient's wishes, or, if those wishes are unknown, the signer's assessment of the patient's best interests.

Signature of patient, health care agent, guardian* or parent/guardian* of minor	**Date of Signature**

Print name and contact number(s) for person signing Section D

E Signature of Physician, NP or PA

Signature of Physician, Nurse Practitioner (NP) or Physician Assistant (PA) Signature confirms this form accurately reflects discussion(s) with Section D signer	**Date of Signature**

Print name and contact number(s) for person signing Section E

Record of Periodic Review: Upon review, if *no change* to this form is needed, the Physician, NP or PA should sign and print name and contact number(s) below:	**Date reviewed with Section D signer**
1.	
2.	
3.	
4.	

Patient's name: _____

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment

F

Patient's Preferences for Other Medically-Indicated Treatments

Section F is valid only when signed and dated at the bottom of Section F.

Respiratory Support

Only select one circle →

- ○ No non-invasive ventilation
- ○ Use non-invasive ventilation
- ○ Use non-invasive ventilation, but short term only
- ○ Undecided
- ○ Did not discuss

Dialysis Support

Only select one circle →

- ○ No dialysis
- ○ Use dialysis
- ○ Use dialysis, but short term only
- ○ Undecided
- ○ Did not discuss

Artificial Nutrition

Only select one circle →

- ○ No artificial nutrition
- ○ Use artificial nutrition
- ○ Use artificial nutrition, but short term only
- ○ Undecided
- ○ Did not discuss

Artificial Hydration

Only select one circle →

- ○ No artificial hydration
- ○ Use artificial hydration
- ○ Use artificial hydration, but short term only
- ○ Undecided
- ○ Did not discuss

Other treatment preferences

_____

_____

Signature of patient or health care agent, guardian* or parent/guardian* of minor patient

_____

Print name of person signing Section F _____

Date of Signature

*A guardian can sign to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.

- ► If signed by the patient, confirms that the patient signed of own free will and that Section F reflects his/her treatment preferences on the date signed.
- ► If signed by the health care agent, guardian* or parent/guardian* of a minor patient, confirms that Section F reflects the signer's assessment of the patient's preferences, or, if those preferences are unknown, the signer's assessment of the patient's best interests.

G Health Care Agent

Print name and contact number(s) of patient's health care agent, if agent has not signed this form.

Name _____ **Contact number** _____

Directions for Health Care Professionals

Honoring the MOLST Form

- Follow orders listed in A, B and C until there is an opportunity for a Physician, NP or PA to reassess the clinical situation.
- The patient or health care agent (if the patient lacks capacity), guardian* or parent/guardian* of a minor patient can request and receive previously refused treatment at any time.

Changing the MOLST Form

- The patient's preferences should be re-discussed periodically and the MOLST form updated whenever: the patient is transferred from one care setting or level of care to another, or there is a significant change in the patient's health status, or if the patient's treatment preferences change.
- If the review indicates:
  - ***No change*** to the MOLST, the Physician, NP or PA should sign and date the review panel at the bottom of page one to indicate that the form is current as of the date reviewed.
  - ***Change*** to the MOLST, the Physician, NP or PA must void this form by writing the word VOID in large letters across both pages of the form.
- After voiding the form, a new form should be completed. *If no new form is completed, no limitations on treatment are documented and full treatment and resuscitation may be provided.*

Completing the MOLST Form

- Complete a MOLST form after conversation(s) based on the patient's current medical condition and preferences for medically-indicated treatments at the time of signing.
- For a valid MOLST form, both Section D (patient info) and Section E (clinician info) must by *fully* completed