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 patient’s 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 a 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.

<table>
<thead>
<tr>
<th>A</th>
<th>CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>O Do Not Resuscitate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>VENTILATION: for a patient in respiratory distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>O Do Not Intubate and Ventilate</td>
</tr>
<tr>
<td></td>
<td>O Intubate and Ventilate</td>
</tr>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>O Do Not Use Non-invasive Ventilation (e.g. CPAP)</td>
</tr>
<tr>
<td></td>
<td>O Use Non-invasive Ventilation (e.g. CPAP)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>TRANSFER TO HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>O Do Not Transfer to Hospital (unless needed for comfort)</td>
</tr>
<tr>
<td></td>
<td>O Transfer to Hospital</td>
</tr>
</tbody>
</table>

Select one circle below to indicate who is signing Section D:

- Patient
- Health Care Agent
- Guardian*
- Parent/Guardian* of minor

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

<table>
<thead>
<tr>
<th></th>
<th>Signature of Patient (or Person Representing the Patient)</th>
<th>Date of Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legible Printed Name of Signer</td>
<td>Telephone Number of Signer</td>
</tr>
</tbody>
</table>

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

<table>
<thead>
<tr>
<th></th>
<th>Signature of Physician, Nurse Practitioner, or Physician Assistant</th>
<th>Date of Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legible Printed Name of Signer</td>
<td>Telephone Number of Signer</td>
</tr>
</tbody>
</table>

This form does not expire unless expressly stated. Expiration date (if any) of this form: _______________

<table>
<thead>
<tr>
<th></th>
<th>Health Care Agent Printed Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Physician Printed Name</td>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.
## Statement of Patient Preferences for Other Medically-Indicated Treatments

### INTUBATION AND VENTILATION
- Refer to Section B on Page 1
- Select one circle:
  - Use intubation and ventilation as checked in Section B, but short term only
  - Undecided
  - Did not discuss

### NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)
- Refer to Section B on Page 1
- Select one circle:
  - Use non-invasive ventilation as checked in Section B, but short term only
  - Undecided
  - Did not discuss

### DIALYSIS
- Select one circle:
  - No dialysis
  - Use dialysis
  - Use dialysis, but short term only
  - Undecided
  - Did not discuss

### ARTIFICIAL NUTRITION
- Select one circle:
  - No artificial nutrition
  - Use artificial nutrition
  - Use artificial nutrition, but short term only
  - Undecided
  - Did not discuss

### ARTIFICIAL HYDRATION
- Select one circle:
  - No artificial hydration
  - Use artificial hydration
  - Use artificial hydration, but short term only
  - Undecided
  - Did not discuss

### Other treatment preferences specific to the patient's medical condition and care

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**PATIENT or patient's representative signature**

**G Required - Select circle and fill in every line for valid orders**

**Select one circle below to indicate who is signing Section G:**
- Patient
- Health Care Agent
- Guardian*
- Parent/Guardian* of minor

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

- Signature of Patient (or Person Representing the Patient)
- Date of Signature

- Legible Printed Name of Signer
- Telephone Number of Signer

**H Required - Fill in every line for valid orders**

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 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.