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 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.

A
Select one circle ➔

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

0 Do Not Resuscitate 0 Attempt Resuscitation

B
Select one circle ➔

VENTILATION: for a patient in respiratory distress

0 Do Not Intubate and Ventilate 0 Intubate and Ventilate

Select one circle ➔

0 Do Not Use Non-invasive Ventilation (e.g. CPAP) 0 Use Non-invasive Ventilation (e.g. CPAP)

C
Select one circle ➔

TRANSFER TO HOSPITAL

0 Do Not Transfer to Hospital (*unless needed for comfort*) 0 Transfer to Hospital

PATIENT or patient's representative signature

D

Required
Select circle and fill in every line for valid orders

Select one circle below to indicate who is signing Section D:
o Patient o Health Care Agent o Guardian* o 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.*

X _____ _____
Signature of Patient (or Person Representing the Patient) Date of Signature

_____ _____
Legible Printed Name of Signer Telephone Number of Signer

CLINICIAN signature

E

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 D.

X _____ _____
Signature of Physician, Nurse Practitioner, or Physician Assistant Date of Signature

_____ _____
Legible Printed Name of Signer Telephone Number of Signer

Optional
Expiration date and other patient care contacts

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

Health Care Agent Printed Name _____ Telephone Number _____

Primary Care Provider Printed Name _____ Telephone Number _____

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

Select one circle ➔

O Refer to Section B on Page 1	O Use intubation and ventilation as checked in Section B, but short term only	O Undecided O Did not discuss

NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)

Select one circle ➔

O Refer to Section B on Page 1	O Use non-invasive ventilation as checked in Section B, but short term only	O Undecided O Did not discuss

DIALYSIS

Select one circle ➔

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

ARTIFICIAL NUTRITION

Select one circle ➔

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

ARTIFICIAL HYDRATION

Select one circle ➔

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

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

_____

_____

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:

o Patient o Health Care Agent o Guardian* o 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.*

X _____ _____

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

_____ _____

Legible Printed Name of Signer Telephone Number of Signer

CLINICIAN signature

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.

X _____ _____

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.