Medical Orders for Life-Sustaining Treatment (MOLST)

This Medical Orders for Life-Sustaining Treatment (MOLST) form is generally for patients with advanced illness who require long-term care services and/or who might die within 1-2 years.* The MOLST may also be used for individuals who wish to avoid and/or receive specific life-sustaining treatments. A physician, nurse practitioner, or physician assistant reviews the patient's current health status, prognosis, goals for care, and the risks and benefits of each life-sustaining treatment with the patient if they have capacity, or the health care agent or surrogate if the patient lacks capacity.

All ethical and legal requirements must be followed, including special procedures when a patient has an intellectual or developmental disability and lacks capacity. If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the physician (not a nurse practitioner or physician's assistant) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) MOLST Legal Requirements Checklist for Individuals with I/DD before signing the MOLST. (OPWDD checklist available at **https://opwdd.ny.gov/providers/health-care-decisions**). For more information on requirements for completing the MOLST, see page 4.

This MOLST may not be changed without the consent of the patient (or their health care decision-maker if the patient lacks capacity). Completing a MOLST is voluntary and cannot be required. The patient should keep this original MOLST with them at all times, whenever they leave home and during travel to different care settings. The physician, nurse practitioner, or physician assistant keeps a copy. All health care professionals and emergency medical services (EMS) providers are required to follow these medical orders. HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment. For further information on MOLST, see **https://www.health.ny.gov/professionals/patients/patient_rights/molst/**

SECTION A Patient Information

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS/CITY/STATE/ZIP

PREFERRED PHONE NUMBER | DATE OF BIRTH (MM/DD/YYYY) | eMOLST NUMBER (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 Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check **one:**

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**

SECTION C 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, includes tracheostomy
- ☐ A trial of non-invasive ventilation and/or intubation and mechanical ventilation*
- ☐ A trial of non-invasive ventilation only; if fails, Do Not Intubate*
- ☐ Do Not Intubate (DNI) and Do Not Use Non-invasive Ventilation or Mechanical Ventilation

Future Hospitalization/Transfer

Check **one:**
- ☐ Send to the hospital, when medically necessary
- ☐ Send to the hospital only if pain and severe symptoms cannot be controlled
- ☐ Do not send to the hospital

SECTION D Consent for Sections B and C

SIGNATURE OF INDIVIDUAL MAKING DECISIONS | PRINTED NAME OF INDIVIDUAL MAKING DECISIONS

☐ Verbal consent, leave signature line blank

DATE/TIME OF CONSENT

Who is the individual making decisions:

☐ Patient ☐ Health Care Agent ☐ FHCDA Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate for individual with I/DD

PRINTED NAME OF FIRST WITNESS* | PRINTED NAME OF SECOND WITNESS

*If this decision relates to an individual with an intellectual or developmental disability, refer to the instructions on page 4 before proceeding.

SECTION E Physician/Nurse Practitioner/Physician Assistant Signature for Sections B and C

If Section D is completed by a §1750-b Surrogate, a physician must sign this Section E. Prior to the physician signing this Section E when Section D is completed by a §1750-b Surrogate, the physician must complete and attach the OPWDD Checklist.

SIGNATURE | PRINT NAME

LICENSE NUMBER | DATE/TIME

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

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 primary goal of relieving pain and other symptoms

ARTIFICIALLY ADMINISTERED FLUID AND NUTRITION

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 occurs*
☐ 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 | PRINTED NAME OF INDIVIDUAL MAKING DECISIONS

☐ Verbal consent, leave signature line blank

DATE/TIME OF CONSENT

Who is the individual making decisions:

☐ Patient ☐ Health Care Agent ☐ FHCDA Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate for individual with I/DD

PRINTED NAME OF FIRST WITNESS* | PRINTED NAME OF SECOND WITNESS

*If this decision relates to an individual with an intellectual or developmental disability, refer to the instructions on page 4 before proceeding.

SECTION H Physician/Nurse Practitioner/Physician Assistant Signature for Section F

If consent for this order 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.t.

SIGNATURE | PRINT NAME

LICENSE NUMBER | DATE/TIME

This MOLST form has been approved by the NYSDOH for use in all settings.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT	DATE OF BIRTH (MM/DD/YYYY)

SECTION I Review and Renewal

A physician, nurse practitioner, or physician assistant should review this form at least every 90 days and whenever the patient or other decisionmaker changes their mind about treatment. The MOLST should 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).

This MOLST remains valid and must be followed even if it has not been reviewed in the 90-day period.

Date/Time	Reviewer's Printed Name and Signature	Location of Review	Outcome of Review
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
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LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

In addition to the MOLST form, the New York State Department of Health and OPWDD have developed legal requirements checklists and instructions to assist in the proper completion of the MOLST. The checklists are intended to assist providers in satisfying the ethical and legal requirements associated with decisions concerning life-sustaining treatment for all patients.

Adult Patients

The instructions and legal requirements checklists for **adult patients** can be found at **www.health.ny.gov/professionals/patients/patient_rights/molst/**. For adult patients, there are five different checklists. The correct checklist should be chosen based on the patient's decision-making capacity and the setting.

- **Checklist #1** Adult patients with medical decision-making capacity - any setting
- **Checklist #2** Adult patients without medical decision-making capacity who have a health care proxy - any setting
- **Checklist #3** Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, decision-maker is Public Health Law Surrogate
- **Checklist #4** Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the list is available
- **Checklist #5** Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community

A Public Health Law Surrogate (aka a FHCDA Surrogate) means a surrogate under Public Health Law Article 29-CC (the Family Health Care Decisions Act).

Minor Patients

The instructions and legal requirements checklists for **minor patients** can be found at: www.health.ny.gov/professionals/patients/patient_rights/molst/

Individuals with Intellectual or Developmental Disabilities (I/DD)

The law governing the decision-making process differs for individuals with I/DD. Surrogate's Court Procedure Act Section 1750-b (SCPA 1750-b) must be followed when making a decision for an individual with I/DD who is determined to lack capacity and who does not have a health care proxy.

- **Sections E and H of this form may only be signed by a physician,** not a nurse practitioner or physician's assistant.
- In sections D and G of this form, **one witness must be the individual's treating physician.**
- Completion of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD, including notification of certain parties and resolution of any objections, is **mandatory prior to completion of a MOLST.**
- Both the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD and SCPA 1750-b process apply to individuals with I/DD, r**egardless of their age or residential setting.**
- **Decisions to withhold or withdraw life sustaining treatment (LST) for an individual with I/DD** must be specifically listed and described in step 2 of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD and only after the surrogate has had a discussion with the individual's treating physician regarding their medical condition, possible treatment options and goals for care. SCPA 1750-b also requires that two physicians determine that the individual's condition meets specific medical criteria **at the time the request to withhold or withdraw treatment is being made,** including that the provision of the life sustaining treatment would impose an extraordinary burden on the individual. These requirements are included in step 4 of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD. The individual's medical condition for the purposes of a request to withhold or withdraw LST **must never include consideration of their intellectual or developmental disability.**
- Trials for an individual with I/DD: Whether or not a new checklist is required following an unsuccessful trial of LST depends on the parameters of the trial, as specified in step 2 of the OPWDD MOLST Legal Requirements Checklist for individuals with I/DD. **If a trial period is open ended, and the authorized surrogate subsequently decides to request withdrawal of the LST, a new checklist is required.**

The complete instructions and legal requirements checklists for **people with intellectual or developmental disabilities** can be found at: **www.opwdd.ny.gov/providers/health-care-decisions** or at **www.health.ny.gov/professionals/patients/patient_rights/molst/**.