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 | Printed Name of Individual Making Decisions

☐ For verbal consent only, leave signature line blank

☐ Written consent, sign above

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
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ Form voided, no new form
			☐ No change ☐ Form voided; new form completed ☐ 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.**

General Instructions for Completing the MOLST

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. The laws governing the decision-making process for adult and minor patients who are determined to lack capacity to make MOLST decisions are the Health Care Proxy Law, Public Health Law (PHL) 29-C; Family Health Care Decisions Act (FHCDA), PHL Articles 29-CC & CCC; and Surrogate's Court Procedure Act (SCPA) Section 1750-b. Use of the DOH checklists are recommended (but not required) to facilitate proper compliance with the legal requirements under NYS Law for patients of any age. Completion of the OPWDD Checklist is required prior to completion of the MOLST for any adult or minor with an intellectual or developmental disability who lacks capacity to make medical decisions and does not have a health care proxy. All witnesses must personally observe the provision of consent, whether provided verbally or in writing.

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

Adult Patients
For adult patients, there are five different DOH checklists. The correct checklist should be chosen based on the patient's decision-making capacity and the setting.

- **DOH Checklist #1** Adult patients with medical decision-making capacity in any setting
- **DOH Checklist #2** Adult patients without medical decision-making capacity who have a health care proxy - any setting
- **DOH 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 FHCDA surrogate
- **DOH Checklist #4** Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy for whom no FHCDA surrogate from the list is available
- **DOH Checklist #5** Adult patients in the community without medical decision-making capacity who do not have a health care proxy

Minor Patients Using a FHCDA Surrogate

- **DOH Checklist #6 for Minor Patients** – Minor patients for whom decisions are being made under the FHCDA

* Instructions if the Medical Orders are for an Adult or Minor Patient with an Intellectual or Developmental Disability (I/DD)

The **OPWDD MOLST Legal Requirements Checklist** is REQUIRED for a patient of any age with an I/DD who lacks capacity and does not have a health care proxy, regardless of their residential setting. For a patient with an I/DD, the completed OPWDD MOLST Legal Requirements checklist must remain attached to the paper/printed MOLST form for it to be valid.

The law governing the decision-making process differs for adults and minors with I/DD. Surrogate's Court Procedure Act Section (SCPA) Section 1750-b must be followed when making a decision for an adult or minor 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 assistant.
- In sections D and G of this form, **one witness must be the individual's treating physician**.
- Review(s) in Section I of this form **may only be conducted by a physician**, not a nurse practitioner or physician assistant.
- 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 adult and minor patients with I/DD, **regardless of their age or residential setting.**
- **Decisions to withhold or withdraw life sustaining treatment (LST) for an adult or minor 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 patient'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 patient'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 adult or minor patient 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.**
- If the patient resides in or was transferred from an OPWDD facility, additional witnessing requirements exist for the execution of a health care proxy.

The complete instructions and legal requirements checklist for **adult and minor patients with intellectual or developmental disabilities** can be found at:
www.opwdd.ny.gov/providers/health-care-decisions