Honoring Choices® MASSACHUSETTS

Massachusetts Health Care Proxy Instructions and Document

Instructions: Every competent adult, 18 years old and older, has the right to appoint a Health Care Agent in a Health Care Proxy. To create your Health Care Proxy, print this two page form and place the instructions page and the blank document in front of you. Follow the step-by-step instructions and sign and date the Health Care Proxy in front of two witnesses, who sign and date the document after you.

1. Your Name and Address (Required)
Print your full name in the blank space. Print your address.

2. My Health Care Agent is: (Required)
Print the name, address and phone numbers of your Health Care Agent.
- Choose a person you trust to make health care decisions for you based on your choices, values and beliefs, if you cannot make or communicate decisions yourself;
- Your Health Care Agent and Alternate Agent cannot be a person who is an operator, administrator or employee in the facility where you are a patient or resident or have applied for admission, unless they are related to you by blood, marriage or adoption.

3. My Alternate Health Care Agent (Not required, but helpful to have an Alternate Agent)
If possible, appoint a person you trust as a back-up or Alternate Agent, who can step-in to make health care decisions if your Health Care Agent is not available, not willing or not competent to serve, or is not expected to make a timely decision. Print the name, address and phone numbers.

4. My Health Care Agent's Authority (Required)
Here's where you give your Agent either the broadest possible decision-making authority to make "any and all" decisions including life sustaining treatments, or limit his/her authority:
- If you want to give "any and all" decision-making authority, just leave this area blank.
- If you do not want to give "any and all" decision-making authority, describe the way in which you want to limit your Agent's authority and write it down in the space provided.

5. Signature and Date (Required)
Do NOT sign ahead. Sign your full name & date in front of two adult witnesses who sign after you.
- You can have someone sign your name at your direction in front of two witnesses.

6. Witness Statement and Signature (Required)
Any competent adult can be a witness except your Health Care Agent and Alternate Agent.
- Two adults must be present as witnesses when this document is signed. They watch as you sign the document, or as another person signs at your direction, and sign after you to state that you are at least 18 years old, of sound mind, and under no constraint or undue influence. ! Have Witness One sign, then print his or her name and the date;
- Then have Witness Two sign and print his or her name and the date.

7. Health Care Agent Statement (Optional)
This section is not required, but it can help your doctors and family know the Agents you appointed have accepted the position. Your Agent(s) signs and prints the date in the spaces provided.

Important: Keep your original Health Care Proxy. Make a copy and give it to your Health Care Agent. Give a copy to your doctors and care providers to scan in your medical record so they know how to contact your Agent if you are ill or injured and unable to speak for yourself.

Massachusetts Health Care Proxy

1. I, _____ Address: _____,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

2. My Health Care Agent is:

Name: _____ Address: _____

Phone(s): _____; _____; _____

3. My Alternate Health Care Agent

If my Agent is not available, willing or competent, or not expected to make a timely decision, I appoint:

Name: _____ Address: _____

Phone(s): _____; _____; _____

4. My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make any and all health care decisions including life-sustaining treatment decisions, except (list limits to authority or give instructions, if any):

_____

_____.

I authorize my Health Care Agent to make health care decisions based on his or her assessment of my choices, values and beliefs if known, and in my best interest if not known. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

5. Signature and Date. I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED _____ **DATE** _____

6. Witness Statement and Signature

We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence. Neither of us is the health care agent or alternate agent.

Witness One		***Witness Two***	
Signed:	_____	Signed:	_____
Print Name:	_____	Print Name:	_____
Date:	_____	Date:	_____

7. Health Care Agent Statement (Optional):

We have read this document carefully and accept the appointment.

Health Care Agent _____ Date _____

Alternate Health Care Agent _____ Date _____

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 signing 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 any 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

Mark one circle ➔

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

☐ Do Not Resuscitate ☐ Attempt Resuscitation

B

Mark one circle ➔

VENTILATION: for a patient in respiratory distress

☐ Do Not Intubate and Ventilate ☐ Intubate and Ventilate

Mark one circle ➔

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

C

Mark one circle ➔

TRANSFER TO HOSPITAL

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

PATIENT or patient's representative signature

D

Required

Mark one circle and fill in every line for valid Page 1.

Mark 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 only to the extent permitted by MA law. Consult legal counsel with questions about a 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 Page 1.

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 and Time of Signature

_____ _____

Legible Printed Name of Signer Telephone Number of Signer

Optional

Expiration date (if any) and other information

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

Mark one circle ➔

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

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

Mark one circle ➔

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

DIALYSIS

Mark one circle ➔

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

ARTIFICIAL NUTRITION

Mark one circle ➔

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

ARTIFICIAL HYDRATION

Mark 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 _____

_____

_____

PATIENT or patient's representative signature — G — *Required*

Mark one circle and fill in every line for valid Page 2.

Mark 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 only to the extent permitted by MA law. Consult legal counsel with questions about a 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 Page 2.

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

Massachusetts Medical Orders for Life-Sustaining Treatment

IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.

- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.

- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.

- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients.

- Listen to *MOLST Overview for Health Professionals* at: http://www.molst-ma.org/molst-training-line.

- Access the MOLST website at: http://www.molst-ma.org periodically for MOLST form updates.

- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit http://www.molst-ma.org.

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* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at http://www.staples.com, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at http://www.officedepot.com.

Honoring Choices®
MASSACHUSETTS

Personal Directive

Short Form: Instructions and Document

A Personal Directive is a personal document, not legally binding in Massachusetts, in which you give your Health Care Agent ("Agent"), family, doctors and care providers information about what's important to you and instructions about the kind of care you want and do not want. Your Personal Directive acts as your voice when you are unable to communicate or make care decisions for yourself.

- If you have chosen an Agent in a Health Care Proxy, your Agent uses your Personal Directive as a basis to make health care decisions on your behalf, and to talk with others about your care.
- If you have not chosen an Agent yet, your Personal Directive gives important information to your family, doctors and care providers to help them match quality care to your values and choices.

Instructions: Print this document and place the instructions page and blank form side by side in front of you. Follow the instructions and write in what you'd like others to know about your values, beliefs, goals and choices. Use both sides for more space. You can make changes anytime, as long as you are competent.

On the first line print your full name in the blank space, followed by your address. Check the box that applies about your Agent. If you have a Health Care Proxy, you can attach it to this document.

I. My Personal Preferences, Thoughts and Beliefs

- Let others know what's most important to you (family, friends, work, faith, activities…)
- Write in anything you like to help others match care & services to your values and choices.
- Add information to help others manage your personal affairs while you recover or longer.

II. People to Inform about My Choices and Preferences

- List the names of family, friends and others you'd like to inform, and how they can help.

III. My Medical Care: My Choices and Treatment Preferences

- A. Current Medical Condition: Share information and your care preferences.
- B. Life-Sustaining Treatments: Cardiopulmonary resuscitation (CPR), artificial ventilation and breathing, and artificial hydration and nutrition are treatments intended to prolong life by supporting an essential body function, when the body is not able to function on its own. Talk to your doctors about the risks, benefits and possible outcomes of attempting these treatments given your medical condition. Check the box or write in your instructions.

IV. Other Information, Instructions and Personal Messages:

- Write in (and attach additional pages) to provide information about your care, instructions for managing your personal affairs or pets, or personal messages to deliver to others.

V. SIGNATURE and Date

- Sign your full name and fill in the date as you sign it. You can revise or reaffirm this document.

Important: Keep the original and give a copy to your Agent, family, doctors and anyone else you would like. You can make changes or add information all through your life, as long as you are competent. Read more about the Personal Directive at www.honoringchoicesmass.com

Personal Directive

I, _____, residing at _____, write this directive for my Health Care Agent (Agent), family, friends, doctors and care providers to inform you of my choices and preferences for care.

☐ I have chosen a Health Care Agent in a Health Care Proxy. My Agent's Name & Contact Information is:
_____

☐ I have not chosen a Health Care Agent in a Health Care Proxy.

I. My Personal Preferences, Thoughts and Beliefs

1. Here's what is most important to me, and the things that make my life worth living:

_____

_____

2. If I become ill or injured and I am expected to recover, possibly to a lesser degree, here's how I define having a good quality of life. I'd like to be able to:

_____

_____

3. Here are my personal values, my religious or spiritual beliefs, and my cultural norms and traditions to consider when making decisions about my care (list here if any):

_____

_____

4. Here's what worries me most about being ill or injured; here's what would help lessen my worry:

_____

_____

5. If I become seriously ill or injured and I am not expected to recover and regain the ability to know who I am, here are my thoughts about prolonging my life and what treatments are acceptable and not acceptable to me:

_____

_____

6. Here are my thoughts about what a peaceful death looks like to me:

_____

_____

II. People to Inform about My Choices and Preferences

Here's a list of people to inform (i.e. family, friends, clergy, attorneys, care providers) their contact information, and the role or action I'd like each to take (if any):

_____

_____

_____

III. My Medical Care: My Choices and Treatment Preferences

A. My Current Medical Condition

Here's information about my specific medical condition. Here are my preferences for medications, clinicians, treatment facilities or other care I want or do not want (if any):

_____

_____

B. Life-Sustaining Treatments

1. Cardiopulmonary Resuscitation (CPR) is a medical treatment used to restart the heartbeat and breathing when the heartbeat and breathing have stopped. My choices are:
   - ☐ I do not want CPR attempted but rather, I want to allow a natural death with comfort measures;
   - ☐ I want CPR attempted unless my doctor determines any of the following: • I have an incurable illness or irreversible injury and am dying • I have no reasonable chance of survival if my heartbeat and breathing stop • I have little chance of long-term survival if my heartbeat and breathing stop and the process of resuscitation would cause significant suffering;
   - ☐ I want CPR attempted if my heartbeat and breathing stop;
   - ☐ I do not know at this time and rely on my Health Care Agent to make care decisions.

_____

_____

2. Treatments to Prolong My Life

   If I reach a point where I am not expected to recover and regain the ability to know who I am, here are my choices and preferences for life-sustaining treatment:
   - ☐ I want to withhold or stop all life-sustaining treatments that are prolonging my life and permit a natural death. I understand I will continue to receive pain & comfort medicines;
   - ☐ I want all appropriate life-sustaining treatments for a short term as recommended by my doctor, until my doctor and Agent agree that such treatments are no longer helpful;
   - ☐ I want all appropriate life-sustaining treatments recommended by my doctor;
   - ☐ I do not know at this time and rely on my Health Care Agent to make care decisions.

_____

_____

IV. Other Instructions, Information and Personal Messages

_____

_____

V. Signature and Date

I sign this Personal Directive after giving much thought to my choices and preferences for care.
I understand I can revise, review and affirm my decisions all through my life as long as I am competent.

SIGNED: _____ Date: _____

Reviewed and Reaffirmed_____ Date: _____