THE PATIENT KEEPS THE ORI	INAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.
LAST NAME/FIRST NAME/MIDDLE INITI	L OF PATIENT
ADDRESS	
CITY/STATE/ZIP	
	☐ Male ☐ Female
DATE OF BIRTH (MM/DD/YYYY)	eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)
This is a medical order form that tells form, based on the patient's current m should reflect patient wishes, as best follow these medical orders as the pat	Other Life-Sustaining Treatment (LST) Ithers the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST edical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders inderstood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must ent moves from one location to another, unless a physician examines the patient, reviews the orders and changes them. Serious health conditions. The patient or other decision-maker should work with the physician and consider asking
 the physician to fill out a MOLST for Wants to avoid or receive any o Resides in a long-term care fact Might die within the next year. 	•
If the patient has a developmental d legal requirements checklist.	sability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate
SECTION A Resuscitation	Instructions When the Patient Has No Pulse and/or Is Not Breathing
Check <u>one</u> :	
plastic tube down the throat into	onary Resuscitation and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a che windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when , including being placed on a breathing machine and being transferred to the hospital.
DNR Order: Do Not Attempt Resu This means do not begin CPR, as	scitation (Allow Natural Death) defined above, to make the heart or breathing start again if either stops.
SECTION B Consent for	Resuscitation Instructions (Section A)
	It resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will YS law.
	Check if verbal consent (Leave signature line blank)
SIGNATURE	DATE/TIME
PRINT NAME OF DECISION-MAKER	
PRINT FIRST WITNESS NAME	PRINT SECOND WITNESS NAME
Who made the decision?	t 🔲 Health Care Agent 🔲 Public Health Law Surrogate 🔲 Minor's Parent/Guardian 🔲 §1750-b Surrogate
SECTION C Physician Si	gnature for Sections A and B
PHYSICIAN SIGNATURE	PRINT PHYSICIAN NAME DATE/TIME
PHYSICIAN LICENSE NUMBER	PHYSICIAN PHONE/PAGER NUMBER
SECTION D Advance Dir	ectives
Check all advance directives know. ☐ Health Care Proxy ☐ Living V	•

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY. LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

SECTION E	Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing			
	ment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treather the treatment can be stopped.	atment is started, but turns		
	ines No matter what else is chosen, the patient will be treated with dignity and respect, and health care processed as a section of the secti	oviders will offer		
reducing sufferin will be used to re Limited medical based on MOLST	s only Comfort measures are medical care and treatment provided with the primary goal of relieving pain g. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound lieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as n interventions. The patient will receive medication by mouth or through a vein, heart monitoring and all ot orders.	I care and other measures eeded for comfort.		
	medical interventions The patient will receive all needed treatments.			
☐ Do not intubate (are available for s	tubation and Mechanical Ventilation <i>Check <u>one</u>:</i> DNI) Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into a symptoms of shortness of breath, such as oxygen and morphine. (This box should <i>not</i> be checked if full CP	and out of lungs. Treatments R is checked in Section A.)		
☐ Nonin	tion and mechanical ventilation rasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate ng-term mechanical ventilation, if needed Place a tube down the patient's throat and connect to a breath	ing machine as long as		
☐ Do not send to th	ation/Transfer <i>Check <u>one</u>:</i> e hospital unless pain or severe symptoms cannot be otherwise controlled. tal, if necessary, based on MOLST orders.			
stomach or fluids car	·	ven by a tube inserted in the either a feeding tube or IV		
☐ Determine use or	one: otics. Use other comfort measures to relieve symptoms. limitation of antibiotics when infection occurs. treat infections, if medically indicated.			
Other Instructions	about starting or stopping treatments discussed with the doctor or about other treatments not listed above	(dialysis, transfusions, etc.).		
Consent for Life-S	ustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)			
SIGNATURE	Check if verbal consent (Leave signature line blank)	DATE/TIME		
PRINT NAME OF DECISIO	N-MAKER			
PRINT FIRST WITNESS N	AME PRINT SECOND WITNESS NAME			
Who made the decis	n? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate			
Physician Signatu	re for Section E			
PHYSICIAN SIGNATURE	PRINT PHYSICIAN NAME	DATE/TIME		

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LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT	DATE OF BIRTH (MM/DD/YYYY)		
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Review and Renewal of MOLST Orders on This MOLST Form SECTION F

The physician must review the form from time to time as the law requires, and also:

- 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 changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			 □ No change □ Form voided, new form completed □ Form voided, no new form
			☐ No change☐ Form voided, new form completed☐ Form voided, <i>no</i> 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, <i>no</i> new form
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			☐ No change☐ Form voided, new form completed☐ Form voided, <i>no</i> 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

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SECTION F Review and Renewal of MOLST Orders on This MOLST Form Continued from Page 3

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
Date/ Time	and Jignature	(e.g., nospital, kii, i nysiciali s office)	☐ 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
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