PowerForm Signer Information

Please enter your name and email
to begin the signing process.

Your Role:

Physician *

Your Name:

Your Email:

Please provide information for any other
signers needed for this document.

Role:

Patient/Agent

Name:

Email:

Begin Signing

If there are other 'roles' required for this document to be completed, please enter the name and email of these other recipients. An email will be sent inviting them to sign along with you.

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

O Do Not Resuscitate O Attempt Resuscitation

B — Mark one circle ➔

VENTILATION: for a patient in respiratory distress

O Do Not Intubate and Ventilate O Intubate and Ventilate

Mark one circle ➔

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

C — Mark one circle ➔

TRANSFER TO HOSPITAL

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

EXAMPLE

_____ _____

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 →	O Refer to Section B on Page 1	O Use intubation and ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
Mark one circle →	O Refer to Section B on Page 1	O Use non-invasive ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
DIALYSIS			
Mark one circle →	O No dialysis	O Use dialysis O Use dialysis, but short term only	O Undecided O Did not discuss
ARTIFICIAL NUTRITION			
Mark 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			
Mark 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 _____

_____

_____

G — PATIENT or patient's representative signature

Required

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

Mark 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 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

H — CLINICIAN signature

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

EXAMPLE

_____ _____

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.*