STATE OF NEW YORK – DEPARTMENT OF HEALTH

INTEROFFICE MEMORANDUM

To: Regional Emergency Medical Service Councils
Regional Emergency Medical Advisory Committee Members

From: Edward G. Wronski, Director
Bureau of Emergency Medical Services

Subject: Medical Orders for Life Sustaining Treatment (MOLST)

Date: July 18, 2008

This is to advise you that on July 7, 2009 the Governor signed Chapter 197 of the Laws of 2008 which allows for the use of the MOLST form. The law is effective *immediately*. The Bureau of Emergency Medical Services is preparing a policy statement discussing this law and the use of the MOLST form that will be sent to you and all ambulance and EMS services. MOLST may be honored immediately and used instead of a non-hospital DNR order. The non-hospital DNR order is still a valid document and is an option for a patient. The MOLST form has now been approved as an alternative form.

Ambulance services and others may call you with questions. Please remember that the MOLST form and process is not a Department of Health program although it is supported by us. You may refer them to the WEB page housed at the MOLST Training Center at htttp://www.compassionandsupport.org. It is my understanding an updated EMS page is being prepared by Excellus BlueCross BlueShield to address the training needs of EMS providers since passage of this legislation.

Some key points that will help you answer questions about this law, MOLST and the existing DNR form are:

1. MOLST may be used instead of a non-hospital DNR form.
2. The non-hospital DNR form is still a valid form.
3. The MOLST form provides DNR information. It also contains instruction for advanced life support providers on whether to intubate the patient or not when the patient has progressive or impending pulmonary failure without acute cardiopulmonary arrest.
4. The MOLST form is a bright pink, multiple paged form that is easily identified.
5. The MOLST includes information to be used in other health care settings such as the hospital.

Once the bureau policy is finalized we will place it on the WEB and include a link to the MOLST site.

Please call me if you have any questions.

Cc: Dr. Mark Henry
Dr. Deborah Funk
EMS Program Agencies
DOH Regional Offices

MOLST

Medical Orders for Life-Sustaining Treatment

Do-Not-Resuscitate (DNR) and other Life-Sustaining Treatments (LST)

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

This is a Physician's Order Sheet based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Section A is not completed, there are no restrictions for this section. When the need occurs, *first follow* these orders, then contact physician. Any section not completed implies full treatment for that section.

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status (improvement or deterioration), or
- The patient/resident treatment preferences change

Section A

Check One Box Only

RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest):

(If patient/resident has no pulse and/or no respirations)

☐ **Do Not Resuscitate (DNR)*** **[DNR = No cardiopulmonary resuscitation, endotracheal intubation or mechanical ventilation]**

☐ **Full Cardio-Pulmonary Resuscitation (CPR) – No Limitations**

* For incapacitated adults; and/or for therapeutic or medical futility exceptions; and/or for residents of OMH, OMRDD or correctional facilities, also complete relevant sections of Supplemental DNR Documentation Form for Adults. For minor patients, also complete Supplemental DNR Documentation Form for Minors. For patients in the community, also complete NYS DOH Nonhospital DNR Form, unless located in Monroe or Onondaga Counties.

Section B

Patient/ Resident/ Health Care Agent or Surrogate Decision-Maker Consent for Section A

Complete one of the subsections of Section B

DNR (CPR) CONSENT OF PATIENT/RESIDENT WITH DECISION-MAKING CAPACITY:

Section A reflects my treatment preferences.

___________________	___________________	___________________
Patient/Resident Signature ☐ **Check if verbal consent**	**Print Patient/Resident Name**	**Date**
Witness of Patient/Resident Signature or Verbal Consent	**Print Witness Name**	**Date**

DNR (CPR) CONSENT OF HEALTH CARE AGENT (HCA) OR SURROGATE DECISION-MAKER FOR PATIENT / RESIDENT WITHOUT DECISION-MAKING CAPACITY: **This document reflects what is known about the patient/resident's treatment preferences. For Patient/Resident without decision-making capacity, or when medical futility or therapeutic exception is used, Supplemental MOLST Documentation Form MUST be completed and should always accompany this MOLST Form. If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.** ☐ **Prior form attached** ☐ **Supplemental Documentation Form completed**

___________________	___________________	___________________
HCA/Surrogate Signature ☐ **Check if verbal consent**	**Print Name**	**Date**

Relationship to Patient/Resident: ______________________________

___________________	___________________	___________________
Witness Signature	**Print Witness Name**	**Date**

(Must witness HCA/surrogate signature or verbal/telephone consent)

Section C

Physician Signature for Section A and B

Physician Signature for Sections A and B:

___________________	___________________	___________________
Physician Signature *(Must Witness Patient/Resident Signature or Verbal Consent)*	**Print Physician Name**	**Date**

Physician License #: ______________________ **Physician Phone/Pager #:** ______________________

It is the responsibility of the physician to determine, within the appropriate period, (see below) whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the appropriate time period. The **physician must review these orders** as follows: **Hospital: at least every 7 Days; Nursing Home/Skilled Nursing Facility: at least every 60 Days; Nonhospital/Community Setting: at least every 90 Days**

Section D

ADVANCE DIRECTIVES: **Patient/Resident has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity:**

☐ **Health Care Proxy** ☐ **Living Will**

SAMPLE

Section E

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATION: (If patient/resident has pulse and/or is breathing)

This Section is "optional" depending on clinical circumstances and setting. Complete only those sub-sections that are relevant. Blank subsections can be completed at a later date. If patient has decision-making capacity, patient should be consulted prior to treatment or withholding thereof. After confirming consent of appropriate decision-maker, physician must sign and date each subsection at the time of completion.

Physician may complete form for patient with capacity or with Health Care Agent. Include Section E consent.

ADDITIONAL TREATMENT GUIDELINES: (Comfort measures are always provided.)

☐ **Comfort Measures Only** – The patient is treated with dignity and respect. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction are used as needed for comfort. *Do Not Transfer to hospital for life-sustaining treatment. Transfer if comfort care needs cannot be met in current location.*

☐ **Limited Medical Interventions** - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A or E. Guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below. *Transfer to the hospital as indicated.*

☐ **No Limitations on Medical Interventions** - All indicated treatments are provided except as specified in Sections A. *Transfer to the hospital is indicated, including intensive care.*

MD Signature: *Date:*

Physician may complete form for incapacitated patients without Health Care Agent only with clear and convincing evidence. Include Section E consent.

ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS: If patient/resident is DNR, and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

☐ **Do Not Intubate (DNI)**

☐ **A trial period of intubation and ventilation**

☐ **Intubation and long-term mechanical ventilation, if needed**

MD Signature: *Date:*

FUTURE HOSPITALIZATION / TRANSFER: (For long-term care residents and home patients)

☐ **No hospitalization unless pain or severe symptoms cannot be otherwise controlled.**

☐ **Hospitalization with restrictions outlined in Sections A and E.**

MD Signature: *Date:*

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (If Health Care Agent makes decision, it must be based on knowledge of patient/resident's wishes.)

☐ **No feeding tube** (offer food/fluids as tolerated)

☐ **A trial period of feeding tube**

☐ **Long-term feeding tube, if needed**

☐ **No IV Fluids** (offer food/fluids as tolerated)

☐ **A trial of IV fluids**

MD Signature: *Date:*

Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-B.

ANTIBIOTICS:

☐ **No antibiotics** (except for comfort)

☐ **Antibiotics**

MD Signature: *Date:*

OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)

____

____

____

MD Signature: *Date:*

Section E Consent

CONSENT FOR SECTION E OF PERSON NAMED IN SECTION B: Significant thought has been given to life-sustaining treatment. Patient/resident preferences have been expressed to the physician and this document reflects those treatment preferences. As the medical decision-maker, I confirm that the orders documented above in Section E reflect patient/resident's treatment preferences.

Signature ☐ Check if verbal consent	Print Name	Date

SAMPLE

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

RENEW / REVIEW INSTRUCTIONS

MOLST (DNR and Life-Sustaining Treatment)

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- **The patient/resident is transferred from one care setting or care level to another, or**
- **There is a substantial change in patient/resident health status (improvement or deterioration), or**
- **The patient/resident treatment preferences change**

Last Name of Patient/Resident
First Name/Middle Initial of Patient/Resident
Patient/Resident Date of Birth

SAMPLE

How to Complete the MOLST Form

- **MOLST must be completed by a health care professional, based on patient preference and medical indications.**
- **MOLST must be signed by a NYS licensed physician to be valid. Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.**
- **If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.**
- **Use of original form is strongly encouraged. Photocopies and FAXes of signed MOLST are legal and valid.**

How to Review MOLST Form:

Step 1: **Review Sections A through E**

Step 2: **Complete Section F below:**

2a. **If no changes, sign, date and check the "No Change" box.**

2b. **For additions to Section E "optional" directives, complete the relevant subsections(s) after securing consent from the appropriate decision-maker, sign and date subsection(s) in Section E. Then sign, date and check "Changes-Additions only" in box below.**

2c. **For substantive changes, (i.e. reversal of prior directive), write "VOID" in large letters on pages 1 and 2, and complete a new form. Check box marked "FORM VOIDED, new form completed". (RETAIN voided MOLST form in chart or medical record, or as required by law.)**

2d. **If this form is voided and no new form is completed, full treatment and resuscitation will be provided. Write "VOID" in large letters on pages 1 and 2 and check box marked "FORM VOIDED, no new form." (RETAIN voided MOLST form in chart or medical record, or as required by law.)**

Section F

(Review of this Form)

Review of this MOLST Form

Date	Reviewer's Name and Signature	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form

Pages 3 & 4 contain directions and renewals only. **Continue Section F on Page 4**

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

Section F

(Review of this Form)

Review of this MOLST Form *(Con't from Page 3)*

Date	Reviewer	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
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SAMPLE