Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient’s wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient’s current medical condition, values, wishes and MOLST Instructions. 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. A physician 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 physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician 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 a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A

Check one:

☐ CPR Order: Attempt Cardio-Pulmonary Resuscitation
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

☐ Check if verbal consent (Leave signature line blank)  DATE/TIME

SIGNATURE

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME  PRINT SECOND WITNESS NAME

Who made the decision?  ☐ Patient  ☐ Health Care Agent  ☐ Public Health Law Surrogate  ☐ Minor’s Parent/Guardian  ☐ §750-b Surrogate

SECTION C

PHYSICIAN SIGNATURE

PRINT PHYSICIAN NAME  DATE/TIME

PHYSICIAN LICENSE NUMBER

PHYSICIAN PHONE/PAGER NUMBER

SECTION D

Check all advance directives known to have been completed:

☐ Health Care Proxy  ☐ Living Will  ☐ Organ Donation  ☐ Documentation of Oral Advance Directive

DOH-5003 (6/10)  Page 1 of 4

HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.
SECTION E

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines
No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. Check one:

- Comfort measures only  Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- Limited medical interventions  The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- No limitations on medical interventions  The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation  Check one:

- Do not intubate  (DNLI) Do not place a tube down the patient’s throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should not be checked if full CPR is checked in Section A.)
- A trial period  Check one or both:
  - Intubation and mechanical ventilation
  - Noninvasive ventilation (e.g. BIPAP), if the healthcare professional agrees that it is appropriate
- Intubation and long-term mechanical ventilation, if needed  Place a tube down the patient’s throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer  Check one:

- Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.
- Send to the hospital, if necessary, based on MOLST orders.

Artificially Administered Fluids and Nutrition  When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. Check one for feeding tube and IV fluids:

- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube, if needed

- No IV fluids
- A trial period of IV fluids

Antibiotics  Check one:

- Do not use antibiotics. Use other comfort measures to relieve symptoms.
- Determine use or limitation of antibiotics when infection occurs.
- Use antibiotics to 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-Sustaining 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 DECISION-MAKER

PRINT FIRST WITNESS NAME  PRINT SECOND WITNESS NAME

Who made the decision?

- Patient
- Health Care Agent
- Based on clear and convincing evidence of patient’s wishes
- Public Health Surrogate
- Minor’s Parent/Guardian
- §1750-b Surrogate

Physician Signature for Section E

PHYSICIAN SIGNATURE  PRINT PHYSICIAN NAME  DATE/TIME

This MOLST form has been approved by the NYSDOH for use in all settings.