Things to Know About MOLST- Medical Orders for Life-Sustaining Treatment and CC/DNR - Comfort Care/Do Not Resuscitate Orders

1. What is MOLST or Medical Orders for Life-Sustaining Treatment?

MOLST is a medical order and form that communicates a patient’s choices and preferences about life-sustaining treatment to his/her care providers. MOLST is based on an adult’s right to information regarding the risks and benefits of life-sustaining treatments based on their current health condition, and to make informed choices to accept or refuse life-sustaining treatments.

2. Is MOLST a medical document or a personal care planning document?

It’s both. MOLST is a medical document and form that must be signed by your clinician to be valid, but as importantly, MOLST is also a personal care planning document. It’s up to the patient or the patient’s advocates whether to choose to complete a MOLST form as part of their personal health care plan.

3. Is the MOLST form for every adult?

No. The MOLST form is intended to be used by adults with serious advancing illness.

4. How does the MOLST process work?

A clinician or a patient or the patient’s advocates can initiate a discussion about CPR and other life-sustaining treatments given the patient’s current health condition. The discussion works like this:

- The patient receives information regarding the risks and benefits and expected outcomes of attempting CPR and life-sustaining treatments given his/her current health condition;
- The patient chooses what he/she wants for care and does not want for care;
- The patient and clinician can record the patient’s choices on the MOLST form, choosing to fill out just the front side, or both the front and back sides of the form;
- The clinician and patient both sign the MOLST form, and the medical order becomes immediately effective and should be followed by care providers in all treatment settings.

5. Who can have a MOLST discussion and sign the MOLST form?

A clinician and a patient or the patient’s advocates can have a discussion, fill out and sign the MOLST form. The clinicians that have the authority to sign the form are physicians, nurse practitioners and physician assistants. A competent adult who has a serious advancing illness or medical frailty can have a discussion and sign the form, and a Health Care Agent can sign a MOLST form unless expressly limited to do so in the Health Care Proxy. The MOLST form states “A Guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian’s legal authority.”

6. Who can make changes to the MOLST form or revoke/tear up a MOLST form?

A competent adult can always make changes to his/her MOLST form or tear it up or make a new one. The MOLST form is personal and made to reflect a patient’s current care choices and can be changed and added to as a patient’s health needs and choices change over time. A Health Care Agent can make...
changes, or request treatments that the patient or the Agent previously refused, or revoke/tear up the MOLST form, unless the Health Care Proxy expressly limits this power. The MOLST form states, “The patient or health care agent (if the patient lacks capacity) … can revoke the MOLST form at any time and/or request previously refused medically-indicated treatment.”

7. What happens after the clinician and patient sign a MOLST form?

The original MOLST form stays with the patient, and a copy is placed in the patient’s medical record. Copies can be made and given to family, the Agent, and other care providers- anyone the patient chooses. The original MOLST form travels with the patient to any treatment settings.

8. Are copies just as valid as the original MOLST form?

Yes. Faxed copies or photocopies, in any color paper, are valid and should be honored.

9. Who has to follow the decisions on the MOLST Form? What if there are two MOLST forms?

All licensed health professionals (nurses, emergency responders, etc.) should honor a valid MOLST form. EMS (Emergency Treatment Services) personnel must follow the protocols that point to the MOLST form. If there are two MOLST forms, the most recently signed and dated document is valid.

10. What is a Comfort Care/Do Not Resuscitate Order (CC/DNR)? What’s the difference between a CC/DNR and a MOLST form?

A Comfort Care/Do Not Resuscitate Order is a medical form signed by a clinician after a discussion with a patient about the risks and benefits of CPR (Cardiopulmonary Resuscitation) given the patient’s medical outlook, where the patient chooses to have comfort care measures but not to receive CPR if the patient’s heart beat and breathing stop. The CC/DNR form only documents one decision- not to be resuscitated if your heart beat and breathing stop. The MOLST also form contains this decision, but the form gives you the choice to decide: Yes, I do want to be resuscitated or, No, I do not want to be resuscitated. Additionally, MOLST lets you document your preferences and choices about a range of other life-sustaining treatments that could be attempted in the course of your illness.

11. Are the MOLST and CC/DNR forms both valid in Massachusetts?

Yes. Both the MOLST and CC/DNR forms are considered valid and are to be followed by EMS (Emergency Treatment Services) and clinicians to honor the choices of the patient.

12. What if a patient has both a CC/DNR form and a MOLST form?

For cardiac/respiratory arrest, the most recent orders are followed, otherwise MOLST orders apply.

The MA MOLST website has comprehensive information for care providers and consumers. Educational brochures and sample forms are available in 9 languages. www.molst-ma.org
### 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 |
| 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 |

#### D
- MARK ONE CIRCLE BELOW TO INDICATE WHO IS SIGNING SECTION D:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Health Care Agent</th>
<th>Guardian</th>
</tr>
</thead>
</table>

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.

Signature of Patient (or Person Representing the Patient): ____________________________

Date of Signature: ____________________________

Legible Printed Name of Signer: ____________________________

Telephone Number of Signer: ____________________________

#### E
- MARK ONE CIRCLE

| CLINICIAN signature |
| PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT |

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

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.**

Approved by DPH

August 10, 2013

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## MOLST Sample Form – Page 2

**Patient’s Name:** __________  **Patient’s DOB:** __________  **Medical Record # if applicable:** __________

### 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**

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**PATIENT or patient’s representative signature**
- **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 these 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.**

**Signature of Patient (or Person Representing the Patient):** __________  **Date of Signature:** __________

**Legible Printed Name of Signer:** __________  **Telephone Number of Signer:** __________

**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:** __________

**Signature of Physician, Nurse Practitioner, or Physician Assistant:** __________  **Date and Time of Signature:** __________

**Legible Printed Name of Signer:** __________  **Telephone Number of Signer:** __________

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**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, or 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.

Approved by DPH  
August 10, 2013  
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