



## Medical Orders for Life Sustaining Treatment (MOLST)

Follow these orders, then contact a MOLST-Qualified Health Care Provider. This is a **Medical Order Sheet** based upon the person's wishes in his/her current medical condition. Any section not completed implies full treatment. **This MOLST remains in effect unless revised.**

Patient's Last Name \_\_\_\_\_ Patient's First Name \_\_\_\_\_

Gender:  M  F Patient's Date of Birth / / Date/Time Form Prepared \_\_\_\_\_

**A**  
CHECK  
ONE

### CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and is not breathing.*

**Attempt Resuscitation/CPR**  **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When not in cardiopulmonary arrest, follow orders in sections B and C.

**B\***  
CHECK  
ONE

### MEDICAL INTERVENTION: *Patient has a pulse and/or is breathing.*

- Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort.
- Limited Additional Interventions:** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- Full Treatment:** Includes care described above in Comfort Measures Only and Limited Additional Interventions, as well as additional treatment, such as intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated.

**C**  
CHECK  
ONE

### TRANSFER TO HOSPITAL

- Do not transfer to hospital for medical interventions.  Transfer to hospital if comfort measures cannot be met in current location.

**D**  
CHECK  
ONE

### ARTIFICIAL NUTRITION (For example a feeding tube): *Offer food by mouth if feasible and desired.*

- No artificial nutrition  Defined trial period of artificial nutrition  
 Long-term artificial nutrition, if needed  Artificial nutrition until not beneficial or burden to patient

**E**  
CHECK  
ONE

### ARTIFICIAL HYDRATION: *Offer fluid/nutrients by mouth if feasible and desired.*

- No artificial hydration  Defined trial period of artificial hydration  
 Long-term artificial hydration, if needed  Artificial hydration until not beneficial or burden to patient

**F**

### ADVANCE DIRECTIVE (if any): *Check all advance directives known to be completed.*

- Durable Power of Health Care  Health Care Proxy  Living Will  Documentation of Oral Advance Directive

#### Discussed with:

- Patient  Health Care Decision Maker  Parent/Guardian of Minor  Court-Appointed Guardian  Other: \_\_\_\_\_

**G**

### SIGNATURE OF MOLST-QUALIFIED HEALTHCARE PROVIDER (Physician, RNP, APRN, or PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Signature (required) \_\_\_\_\_ Phone Number \_\_\_\_\_ Date/Time / /

Print Name \_\_\_\_\_ Rhode Island License # \_\_\_\_\_

### SIGNATURE OF PATIENT, DECISION MAKER, PARENT/GUARDIAN OF MINOR, OR GUARDIAN

By signing this form, the patient or legally-recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (Required) \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship (if patient, write self) \_\_\_\_\_

Print Name and Address \_\_\_\_\_

**HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY.  
MOLST IS VOLUNTARY. NO PATIENT IS REQUIRED TO COMPLETE A MOLST FORM.**

**Review and Renewal of MOLST Orders on This MOLST Form (this MOLST form remains in effect unless another MOLST form is executed.)**

**The MOLST-Qualified Health Care Provider may 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 (positive or negative); or
- If the patient or other decision-maker changes his/her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, Nursing Home, Provider's Office, Patient's Residence)	Outcome of Review
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <i>no</i> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <i>no</i> new form
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided, new form completed <input type="checkbox"/> Form voided, <i>no</i> new form

**Directions for MOLST-Qualified Health Care Providers Completing MOLST**

- Must be completed by a MOLST-Qualified Health Care Provider based on patient preferences and medical indications. A MOLST-Qualified Health Care Provider is defined as a physician, nurse practitioner, advanced practice registered nurse, or a physician assistant.
- MOLST must be signed by a MOLST-Qualified Healthcare Provider (physician, nurse practitioner, advanced practice registered nurse, or physician assistant) and the patient/decision maker to be valid. Verbal orders are acceptable with follow-up signature by provider in accordance with facility/community policy and documentation that there was discussion with the patient or the patient's advocate about discontinuing the MOLST order.)
- This is the ONLY MOLST FORM that is acceptable for completion in Rhode Island. Do not make your own MOLST form. Photocopies and faxes of signed MOLST forms are legal and valid.
- Any incomplete section of the MOLST form implies full treatment for that section.

**\*Section B:**

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture)
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

**Modifying and Voiding MOLST**

- A patient with capacity can, at any time, void the MOLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new MOLST form.
- To void MOLST draw a line through Sections A through E and write "VOID" in large letters. Sign and date the line.
- A health care decision maker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

**DEFINITIONS**

"Medical orders for life sustaining treatment" or "MOLST" means a voluntary request that directs a health care provider regarding resuscitative and life-sustaining measures. Rhode Island General Laws §23-4.11-2 (10).

"Qualified patient" means a patient who has executed a declaration in accordance with this chapter and who has been determined by the attending physician to be in a terminal condition. Rhode Island General Laws §23-4.11-2 (16).

"Terminal condition" means an incurable or irreversible condition that, without the administration of life sustaining procedures, will, in the opinion of the attending physician, result in death." Rhode Island General Laws §23-4.11-3.1 (20).

This form is approved by the Rhode Island Department of Health. For more information or a copy of the form, visit [www.health.gov](http://www.health.gov)

**SEND MOLST FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.  
Rhode Island General Laws §23-4.11-3.1 authorizes this MOLST form.**

(Rev. 9-2013)