# Photo Album

by Allen Ward

## 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**<br>Mark one circle ➔ | **CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest**<br>O Do Not Resuscitate    O Attempt Resuscitation |
| **B**<br>Mark one circle ➔ | **VENTILATION: for a patient in respiratory distress**<br>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**<br>Mark one circle ➔ | **TRANSFER TO HOSPITAL**<br>O Do Not Transfer to Hospital (*unless needed for comfort*)    O Transfer to Hospital |
| **PATIENT**<br>or patient's representative signature<br>**D**<br>***Required***<br>Mark one circle and fill in every line for valid Page 1. | **Mark one circle below to indicate who is signing Section D:**<br>**o Patient   o Health Care Agent   o Guardian*   o Parent/Guardian* of minor**<br>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.***<br>✘ ____________________ ____________<br>**Signature of Patient (or Person Representing the Patient)**   **Date of Signature**<br>____________________ ____________<br>**Legible Printed Name of Signer**   **Telephone Number of Signer** |
| **CLINICIAN**<br>signature<br>**E**<br>***Required***<br>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.<br>✘ ____________________ ____________<br>**Signature of Physician, Nurse Practitioner, or Physician Assistant**   **Date and Time of Signature**<br>____________________ ____________<br>**Legible Printed Name of Signer**   **Telephone Number of Signer** |
| **Optional**<br>Expiration date (if any) and other information | **This form does not expire unless expressly stated.** *Expiration date (if any) of this form:* ____________<br>Health Care Agent Printed Name ________________ Telephone Number ____________<br>Primary Care Provider Printed Name ________________ Telephone Number ____________ |

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← **Cardiopulmonary Resuscitation**

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| **A** Mark one circle ➔ | **CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest** O Do Not Resuscitate O Attempt Resuscitation |
|---|---|

**B** VENTILATION: for a patient in respiratory distress

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Patient's Name ______________________
Date of Birth ______________________
Medical Record Number if applicable: ____________

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| **A** Mark one circle → | **CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest**<br>O Do Not Resuscitate  O Attempt Resuscitation |
| **B** Mark one circle → | **VENTILATION: for a patient in respiratory distress**<br>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**<br>O Do Not Transfer to Hospital (*unless needed for comfort*)  O Transfer to Hospital |
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| **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.<br>✗ **Signature of Physician, Nurse Practitioner, or Physician Assistant**  **Date and Time of Signature**<br>**Legible Printed Name of Signer**  **Telephone Number of Signer** |
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Ventilation

| **MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org** | **Patient's Name** ____<br>**Date of Birth** ____<br>**Medical Record Number if applicable:** ____ |
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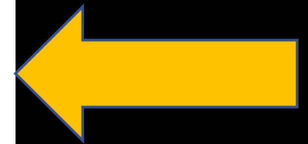
| Mark one circle ➔ | O Do Not Use Non-invasive Ventilation (e.g. CPAP) | O Use Non-invasive Ventilation (e.g. CPAP) |



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**Patient's Name** ______________________

**Date of Birth** ______________________

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**Transfer to Hospital**

| **MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org** | Patient's Name ______<br>Date of Birth ______<br>Medical Record Number if applicable: ______ |
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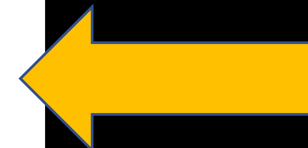
| **A**<br>Mark one circle → | **CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest** | |
| | O Do Not Resuscitate | O Attempt Resuscitation |
| **B**<br>Mark one circle → | **VENTILATION: for a patient in respiratory distress** | |
| | O Do Not Intubate and Ventilate | O Intubate and Ventilate |
| Mark one circle → | O Do Not Use Non-invasive Ventilation (e.g. CPAP) | O Use Non-invasive Ventilation (e.g. CPAP) |
| **C**<br>Mark one circle → | **TRANSFER TO HOSPITAL** | |
| | O Do Not Transfer to Hospital (*unless needed for comfort*) | O Transfer to Hospital |



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 → | ○ Refer to Section B on Page 1 | ○ Use intubation and ventilation as marked in Section B, but short term only | ○ Undecided<br>○ 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<br>○ Did not discuss |
| | **DIALYSIS** | | |
| Mark one circle → | ○ No dialysis | ○ Use dialysis<br>○ Use dialysis, but short term only | ○ Undecided<br>○ Did not discuss |
| | **ARTIFICIAL NUTRITION** | | |
| Mark one circle → | ○ No artificial nutrition | ○ Use artificial nutrition<br>○ Use artificial nutrition, but short term only | ○ Undecided<br>○ Did not discuss |
| | **ARTIFICIAL HYDRATION** | | |
| Mark one circle → | ○ No artificial hydration | ○ Use artificial hydration<br>○ Use artificial hydration, but short term only | ○ Undecided<br>○ Did not discuss |
| | **Other treatment preferences specific to the patient's medical condition and care** ____________________ | | |

| | |
|---|---|
| **PATIENT** or patient's representative signature<br>**G**<br>***Required***<br>Mark one circle and fill in every line for valid Page 2. | **Mark one circle below to indicate who is signing Section G:**<br>**o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor**<br>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.***<br>✘ ____________________ ____________<br>**Signature of Patient (or Person Representing the Patient)** **Date of Signature**<br>____________________ ____________<br>**Legible Printed Name of Signer** **Telephone Number of Signer** |
| **CLINICIAN** signature<br>**H**<br>***Required***<br>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.<br>✘ ____________________ ____________<br>**Signature of Physician, Nurse Practitioner, or Physician Assistant** **Date and Time of Signature**<br>____________________ ____________<br>**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.***

YOUR BIRTH DATE (m/d/y)
____/____/____

# MASSACHUSETTS HEALTH CARE PROXY

**1** I, ______________________________________________, residing at
(Principal: PRINT your name)

______________________________________________
(Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: ______________________________
(Name of person you choose as Agent)

of______________________________________________
(Street) (City/town) (State/ZIP)

Agent's tel (h) ________________ (w) ________________ E-mail ______________

**OPTIONAL**: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

______________________________________________
(Name of person you choose as Alternate Agent)

of______________________________________________
(Street) (City/town) (State/ZIP) (Phone)

**2** My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

**3** **Signed**:______________________________ **Date:** ___/___/___ (mo/day/yr)

**Complete only if Principal is physically unable to sign:** I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

______________________________ (Name)

______________________________ (Street)

______________________________ (City/town) (State/ZIP)

**4** **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.
In our presence, on this day ____/____/____ ( mo / day / yr).

Witness #1 ______________________ (Signature)

Name (print) ______________________

Address ______________________

______________________

Witness #2 ______________________ (Signature)

Name (print) ______________________

Address ______________________

______________________