DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Public Health Preparedness Section

STATE OF DELAWARE MOLST FORM

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

MEDICAL ORDERS for life-sustaining treatment (MOLST)

FIRST follow these orders, THEN contact physician. This is a medical order sheet based on the person's current medical condition and wishes. Any section not complete implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name/First Name/Middle Initial	date of birth	Last 4 SSN #	Gender
_____	___/___/___	___ ___ ___ ___	M☐ F☐

A Check One Box Only

Cardiopulmonary Resuscitation (CPR): **Person has no pulse and is not breathing.***

☐ Attempt Resuscitation (CPR) ☐ Do Not Attempt Resuscitation (DNR/No CPR)

*When person is **not** in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.

B Check One Box Only

Medical Interventions: **Person has a pulse and/or is breathing.**

☐ **COMFORT MEASURES ONLY.** Use medications by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, oral suctioning, and manual treatment of airway obstruction as needed for comfort. ***Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.***

☐ **LIMITED ADDITIONAL INTERVENTIONS.** Includes care described above. Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **FULL TREATMENT.** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

_____

C Check One Box Only

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics If infection occurs, with comfort as goal.

☐ Use antibiotics if life can be prolonged.

Additional Orders:

D Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION:

Always offer food and liquids by mouth, if feasible.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

(Goal): _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

SUMMARY OF MEDICAL CONDITION/GOALS:

F

SIGNATURES: Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient's wishes as best understood by the surrogate.

Discussed with:

☐ Patient ☐ Parent of Minor

☐ Legal Guardian ☐ Next-of-Kin

☐ Health Care Agent

PRINT – Physician/APN/PA Name Phone #

_____

Physician/APN/PA Signature (mandatory) Date

_____

Physician Co-Signature if PA Signs Above (mandatory) Date

_____

Patient or Legal Surrogate Signature/Relationship (mandatory) Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.

Use of original form is strongly encouraged. Photocopies and FAXes of signed MOLST forms are legal and valid.

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Other Contact Information (Please Print)

Name of Guardian, Surrogate, or Other Contact Person _____ Relationship _____ Phone Number _____

Person has: ☐ Health Care Directive (living will) ☐ Power of Attorney for Health Care (POA-HC)
Encourage all advance care planning documents to accompany MOLST

Directions for Health Care Professionals

Completing MOLST

- MOLST must be completed by a health care professional, based on patient preferences and medical indications.
- MOLST should reflect person's current preferences and medical indications. Encourage completion of advance directive.
- MOLST must be signed by a Physician/APN/or PA with Physician co-signature to be valid. Verbal orders are acceptable with follow-up signature by Physician/APN/or PA with physician co-signature in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and FAXes of signed MOLST form are legal and valid.

Using MOLST

Any incomplete section of MOLST implies full treatment for that section.

SECTION A:

- No defibrillator (including AED's) should be used on a person who has chosen "Do Not Attempt Resuscitation."

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).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.
- A person with capacity or the surrogate of a person without capacity can void the form and request alternative treatment.

Reviewing MOLST

This MOLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw a line through "Medical Orders" and write "VOID" in large letters. Any changes require a new MOLST.

Review of this MOLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided and New Form Completed
Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided and New Form Completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.

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Revised June 2011