Family Care Connections, LLC

ADVANCED DIRECTIVES IN NEW YORK STATE

HEALTHCARE PROXY • LIVING WILL
• MEDICAL ORDER FOR LIFE SUSTAINING TREATMENT (MOLST)
• THE FAMILY HEALTHCARE DECISIONS ACT
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What is a Healthcare Proxy?

The New York State Health Proxy Law permits individuals over the age of 18 years of age to appoint a trusted friend or family member to make healthcare decisions if the individual lacks the ability to make their own decisions, due to temporary or permanent incapacity. The health proxy agent will also make sure that healthcare providers follow the wishes of the individual.

In addition, the health proxy agent can make decisions consistent with the individual's wishes as the patient's health condition changes. It is important to understand that healthcare providers must follow the agent's decisions as if the patient was making a decision on their own.

The scope of authority can be tailored to the patient's personal comfort level. It can be specific and limited or more general and limitless. The health proxy can specify how the agent is to decide on specific healthcare issues including organ and or tissue donation.

The health proxy form allows an individual to choose one primary representative and one alternate to make healthcare decisions, if the individual becomes unable to make decisions for themselves. This could involve day-to-day decision-making, care management or extraordinary decisions such as withholding or administering life-sustaining treatment.

It is important to be aware that the agent must reasonably know a person's wishes regarding the withholding of artificial nutrition and hydration in order to make decisions about nourishment and water through an intravenous line. When executing a healthcare proxy the person should clearly state their wishes regarding this treatment. All of this is to avoid any confusion regarding the decision-making authority as it may pertain to artificial nutrition and hydration. The legal standard is "clear and convincing knowledge of the patient's wishes".

Important Consumer Tips

(1) When executing a health proxy it is important to understand that you do not need a lawyer to sign a healthcare proxy.

(2) Only individuals 18 years and older can sign a healthcare proxy.

(3) A health proxy agent can only act if the person is determined by their health care provider to be incapacitated and unable to make their own decisions about healthcare treatment.

(4) The form can have specific wishes and instructions regarding healthcare treatment or the form can set forth general instructions.

(5) Anyone over the age of 18 can act as a healthcare agent. A trusted agent can be a spouse or family member or friend.

(6) If you choose your healthcare provider/doctor as agent, they cannot act as both agent and provider. This is considered a conflict.

(7) Before appointing someone as health proxy agent it is advisable to discuss the proposed appointment with them and make sure they have the ability and desire to act as health proxy agent.

(8) Give the agent a fully executed copy of the document for their own records and make sure they clearly understand and know the parameters of their authority.

(9) If a spouse is appointed, a subsequent divorce will invalidate the document unless it clearly reaffirms the execution of a health proxy to the former spouse. If divorcing, then new and additional planning may be necessary. Consult with an attorney.

(10) Remember, no one can require that a health proxy be executed and it can be revoked at any time.

(11) The document can also provide for organ/tissue donation.

(12) The document is easily executed. It is signed by the person appointing the agent in the presence of two witnesses. Note: It may also be appropriate to simultaneously execute a Living Will when signing the health care proxy. A Living Will deals exclusively with end-of-life issues and life-sustaining treatment and is intended to serve as a guide for healthcare providers and health proxy agents regarding the course of treatment at the end of life. This document is

witnessed by two individuals and the signature of the principle is notarized.

(13) The health proxy agent is never personally liable for healthcare decision making if the decisions were made in good faith. They cannot be held personally responsible for any financial cost.

(14) After signing the health proxy form, give a copy to your treating healthcare provider, attorney and health care proxy agent, as well as close family members and friends. It may be advisable to keep a copy in your wallet or purse and also with other important legal documents.

(15) Do not keep the proxy in a safe deposit box or other place that has limited access. The document should be available 24/7 365 days per year.

(16) Always bring a copy if admitted to a hospital or for an elective procedure.

(17) As of August 26, 2009 the health proxy form can be used to expressed wishes regarding organ and tissue donation as well as healthcare decisions. You can specify a specific donations and the purpose of the donations such as transplantation, research or education.

(18) In the absence of specific intent, agents and family members can also authorize the donation of organs and tissues.

(19) If the primary agent is unavailable for healthcare decision-making, the alternate agent may step in to make decisions.

A copy of the New York State health care proxy form is attached to this article (**See Exhibit #1**)

What is a Living Will?

A Living Will is a written legal document that sets forth the medical wishes/intentions of an individual regarding end-of-life treatment, pain management and organ donation. This document should be used in conjunction with the health care proxy in New York because the Living Will as a stand-alone document is not recognized in the State of New York.

The Living Will is intended to be used to establish the wishes and intentions of the individual regarding end-of-life treatment and the withholding or administration of such treatment. The document is intended to help individuals decide what types of treatment or treatments are consistent with their personal beliefs and values. It is also designed to allow for the possibility that certain care and treatment might be available to lead to an improvement in the person's health situation.

There are numerous end-of-life care decisions, which must be understood and explored in order to create an informed plan. It may be advisable to discuss any questions concerns or issues regarding treatment with your health provider/personal care physician.

The most frequently encountered treatments include cardiopulmonary resuscitation (CPR), mechanical ventilation, tube feeding and hydration,

dialysis, antibiotics or antiviral medication, comfort care or palliative care, organ tissue and body donation for transplantation, research or education. A copy of a Living Will is attached to this article. (**See Exhibit #2**)

What is a Do Not Resuscitate (DNR) or Do Not Intubate (DNI) order?

A Do Not Resuscitate Order (DNR) is a medical order placed in the patient's chart by the treating physician. This order states that in the event of cardiac arrest or respiratory arrest the patient will not be resuscitated (DNR) or intubated (DNI). These types of orders are usually reserved for people suffering from life-threatening illnesses and the patient is at the end stage of the illness.

The patient has to decide if they want a DNR or DNI Order. This is usually based on whether the patient will be subject to unnecessary suffering and resuscitation, or intubation would only serve to prolong the process of dying.

The patient can communicate the wishes to the health provider, or the health proxy representative and they can communicate their wishes to the doctors and the treatment team. If appropriate, the doctor will then place the order in the patient's chart ensuring their wishes are carried out.

(See Exhibit #3)

What is a physician or Medical Order for Life Sustaining Treatment (MOLST)?

The MOLST document is a compilation of a series of medical orders for life-sustaining treatment and is usually utilized when a person is diagnosed with a serious or life-threatening illness. It is a series of instructions that the doctor orders and is a part of a comprehensive assessment/examination folder.

These orders are intended to ensure that a person's wishes are carried out in the case of an emergency and the document is prepared after careful consultation with the patient and/or with the patient's health proxy representative. The MOLST document may include resuscitation, mechanical ventilation, tube feeding, administration of antibiotics and requests to avoid transfer to an emergency room or hospital as well as instructions for pain management.

The MOLST document can be revoked or updated at any time if the patient's health status changes. The document stays with the patient, from one healthcare setting to the next. Therefore, it can be posted and enforced at home, in a hospital, assisted living facility or a nursing home.

If a patient is in a hospice care facility, the document is usually prominently displayed where emergency personnel and the medical treatment team can

easily find the MOLST form. This will ensure that the patient's wishes are carried out in all healthcare settings.

Remember, all advanced directives should be in writing, easily accessible and clearly posted. It is important to make sure all professionals involved in the treatment team are aware of the patient's wishes. This would include the healthcare provider/physician, attorney, care manager, social worker, nursing staff, health proxy representatives, and family members.

Always keep a copy of the advance directives in a wallet or purse especially when traveling. Make sure it is easily available and make sure there is a clear understanding of all healthcare preferences and wishes. It is always advisable to have a clear and frank conversation with the necessary professionals, health representatives and family members regarding treatment wishes. This will insure that the patient's wishes are honored. A copy of a MOLST form is attached to this article. (**See Exhibit #4**)

NEW YORK FAMILY HEALTHCARE DECISIONS ACT

What is the New York Family Healthcare Decisions Act?

The New York Family Healthcare Decisions Act was enacted June 4, 2010, under the Public Health Law Article 29. The law gives a patient's family or close friends authority to make healthcare decisions when a person is determined to lack capacity and did not appoint a health proxy agent.

Does the law apply to all healthcare settings?

No. The Healthcare Decisions Making Act only applies to hospitals and nursing homes and for patients receiving hospice care. There are other laws that govern healthcare decision making for people in institutions under the Office of Mental Health & the Office for People With Developmental Disabilities. In addition, private hospitals and individual care providers are not required to honor decisions made by surrogate's based on personal/conscientious objection or sincerely held religious beliefs and/or moral convictions.

How is a person determined to lack capacity before a surrogate is appointed?

In order to make healthcare decisions, the patient must be determined to lack capacity. It is important to be aware that New York State presumes all adults are capable of making their own healthcare decisions unless a legal guardian has been appointed or a person has been adjudicated incapacitated or incompetent by a court after a hearing.

Please note that this presumption does not extend to minors. There are specific rules regarding minors under the Family Healthcare Decisions Act and initial determinations of incapacity must be made by an attending physician or other authorized practitioner.

In addition, the medical determination must be made with a reasonable degree of medical certainty. The determination must also be based on an assessment that includes the cause of the incapacity and the extent of the capacity, as well as the likelihood that the patient will regain capacity.

For ongoing treatment, the attending practitioner must also confirm a patient's continued lack of capacity when further treatment is necessary. In addition, a concurring determination is required when a patient enters a nursing home. This is done by a social worker or other healthcare professional. They must confirm that the patient continues to lack capacity in order for the surrogate's authority to remain in full force and effect.

When a patient is in a hospital, a concurrent determination is only required if surrogate decision-making includes the withdrawal or withholding of life-sustaining treatment. When a patient is receiving hospice care in a hospital or other nursing home facility the health professional or social service practitioner must be employed by or affiliated with the hospital or nursing home facility.

If there is a disagreement regarding capacity or treatment, the matter must be referred to the ethics review committee at the facility. Also, if the initial determination involves lack of capacity due to mental illness the practitioner must be board-certified or eligible, by the American Board of Psychiatry or Neurology or the American Osteopathic Board of Neurology and Psychiatry In order to make determination regarding capacity.

If the patient lacks capacity due to mental retardation or developmental disability the appropriate agencies such as Developmental Disabilities Services Office (DDSO) must become involved. Before a health practitioner relies on healthcare decisions by a surrogate, a reasonable effort must be made to determine if there is a healthcare proxy agent appointed under Article 29 of the public health law.

After a determination of incapacity has been made, the facility must give notice to the patient and the patient's family. If the patient is transferred from a mental health facility, the Director of the Mental Hygiene facility must be given notice as well.

If the patient objects to the determination of incapacity or with the selection of the surrogate, or the particular health decision made by the surrogate, the patient's objection will usually be honored. The patient's wishes will be disregarded only if the Court has determined that the patient lacks capacity or has been adjudicated incompetent and makes the

authorization of treatment based on the law or that there is another legal basis to override the patient's decision.

Who can act as a surrogate under the Family Healthcare Decisions Act?

The hospital or nursing home will be authorized to recognize the surrogate to make healthcare decisions and major medical decisions under the Family Healthcare Decisions Act in the following order of priority:

(1) Article 81 Guardian

(2) Spouse or Domestic Partner

(3) Adult Child

(4) Parent

(5) Brother or Sister

(6) Close friend aged 18 or older, or other relative who represents and signs a statement to the treating physician that he or she has been in regular contact with the patient and is familiar with the patient's wishes, health, religious and moral beliefs.

What types of health care decisions would the surrogate make?

The surrogate will make decisions about various kinds of treatments. These treatments include routine medical treatment, major medical treatment including general anesthetic, treatment involving significant risk, significant invasion of bodily integrity, physical restraint, psychoactive medication, withholding or withdrawal of life sustaining treatment, as well as decisions regarding hospice care.

What decisions are governed by the Family Healthcare Decisions Act?

The law allows for a surrogate to make all the decisions a patient would make in a hospital or nursing home. The decisions must be consistent with the patient's own decisions as if the patient was not incapacitated. The surrogate's authority does not apply if the patient has already made the decision and expressed their desires orally or in writing.

Also, if the patient made a decision about withdrawing life-sustaining treatment, this decision must be expressed orally during hospitalization in the presence of two witnesses, 18 years of age or older. One of the two witnesses must be a healthcare or social services professional affiliated with the hospital.

The patient can also express their wishes in writing. Once the surrogates authority is established all healthcare decisions must be made in accordance with the patient's wishes, consistent with their religious and/or moral beliefs. If these wishes/beliefs cannot be reasonably determined then decisions can be made in accordance with the Best Interest of the Patient. The surrogate should factor in –

(1) The dignity and uniqueness of every patient.

(2) The possibility and extent of preserving the patient's life.

(3) Preservation, improvement, and rehabilitation of the patient's health or functioning.

(4) Other concerns and values that a reasonable person would wish to consider including relief of the patients suffering.

The surrogate also must meet additional conditions if the patient's care requires withholding of life-sustaining treatment or the imposition of a hospice care plan. They include a determination that the treatment would be an extraordinary burden to the patient and the healthcare practitioner and a concurrent practitioner believes that the patient is likely to die within six months as a result of the injury or illness, with or without treatment, additionally that and the patient is permanently unconscious and provision of treatment will cause great pain and suffering and/or would be burdensome to the patient.

It is important to note that the decision to withdraw all treatment also must be presented to an ethics review committee if the patient is in a nursing home or if the attending physician at the hospital objects to the surrogate's decision to withdraw or withhold nutrition and hydration that is provided as part of the medical treatment.

<u>How does the Family Healthcare Decisions Act effect the do not resuscitate orders?</u>

The Do Not Resuscitate (DNR) order is made in consultation with the surrogate or is made by a relative or close friend in the order previously described. A close friend can make decisions as a surrogate after submitting a statement in writing that describes the nature and closeness of the relationship. The Surrogate or close friend makes sure that the treating

healthcare professional places the Do Not Resuscitate Order (DNR) or Do Not Intubate Order (DNI) in the patient' medical chart.

Making healthcare decisions for another person is a tremendous responsibility. There are significant physical, emotional, psychological, and spiritual consequences to all healthcare decisions. They must be taken seriously and, after thorough contemplation of the patient's wishes and needs and with thorough knowledge of the law as well as the healthcare options available. All decisions should be made in consultation with the patient's healthcare professionals and other personal and professional representatives.

For further information about the Family Healthcare Decisions Act please contact Dr. Frank G. D'Angelo JD, PhD, Family Care Connections, 516-248-9323 or DrFrank@FamilyCareConnections.com

EXHIBIT 1

HEALTH CARE PROXY

HEALTH CARE PROXY

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health

EXHIBIT 2

LIVING WILL

HEALTH CARE DIRECTIVE (LIVING WILL)

I, _____ want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

SECTION 1:

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means (check all that apply):

- ☐ Unconscious (chronic coma or persistent vegetative state)
- ☐ Unable to communicate my needs
- ☐ Unable to recognize family or friends
- ☐ Total or near total dependence on others for care
- ☐ Other: _____

Check only one:

- ☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
- ☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTION 2: (You may leave this section blank.)

Some people do not want certain treatments under any circumstance, even if they might recover.

Check the treatments below that you do not want under any circumstances:

- ☐ Cardiopulmonary Resuscitation (CPR)
- ☐ Ventilation (breathing machine)
- ☐ Feeding tube
- ☐ Dialysis
- ☐ Other: _____

SECTION 3:

When I am near death, it is important to me that: _____

_____

_____

_____

(Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.)

BE SURE TO SIGN PAGE TWO OF THIS FORM

- If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.
- Take a copy of this with you whenever you go to the hospital or on a trip.
- You should review this form often.
- You can cancel or change this form at any time.

FOR MORE INFORMATION CONTACT HEALTH CARE DECISIONS, (602) 222-2229 OR WWW.HCDECISIONS.ORG

HEALTH CARE (MEDICAL) POWER OF ATTORNEY
WITH MENTAL HEALTH AUTHORITY

It is important to choose someone to make healthcare decisions for you when you cannot. **Tell the person (agent) you choose what you would want.** The person you choose has the right to make any decision to ensure that your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** in the line for the agent's name.

I, _____, as principal, designate

_____ as my agent for all matters relating to my health (including mental health) and including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

_____ By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

Print agent ADDRESS and PHONE:

_____

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint:

_____ as my agent.

Print alternate agent ADDRESS and PHONE:

_____

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive forms

Please ask one person to witness your signature who is not related to you or financially connected to you or your estate.

Signature _____ Date _____

The above named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness _____ Date _____

This document may be notarized instead of witnessed.

On this _____day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public _____

FOR MORE INFORMATION CONTACT HEALTH CARE DECISIONS, (602) 222-2229 OR WWW.HCDECISIONS.ORG

EXHIBIT 3

DO NOT RESUSCITATE
(DNR)

NEW YORK STATE DEPARTMENT OF HEALTH

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: _____

Date of Birth: _____

Do not resuscitate the person named above.

*Physician/Nurse Practitioner/
Physician Assistant Signature: _____

Print Name: _____

License Number: _____

Date: _____

It is the responsibility of the physician/nurse practitioner/physician assistant to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.
For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.

EXHIBIT 4

MEDICAL ORDER FOR LIFE SUSTAINING TREATMENT (MOLST)

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

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/nurse practitioner/physician assistant 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/nurse practitioner/physician assistant 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/nurse practitioner/physician assistant and consider asking the physician/nurse practitioner/physician assistant 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 an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the physician (not a nurse practitioner or physician assistant) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

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 Consent for Resuscitation Instructions (Section A)

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. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

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 decisions? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

SECTION C Physician/Nurse Practitioner/Physician Assistant Signature for Sections A and B

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE* PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT NAME DATE/TIME

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT LICENSE NUMBER PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

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

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECTION E — Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

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. Before stopping treatment, additional procedures may be needed as indicated on page 4.**

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 (DNI)** 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 health care 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. **Additional procedures may be needed as indicated on page 4.**
Check one each 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 physician/nurse practitioner/physician assistant 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 decisions? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

Physician/Nurse Practitioner/Physician Assistant Signature for Section E

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE* PRINT PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT NAME DATE/TIME

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

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

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT — DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on this MOLST Form

The physician/nurse practitioner/physician assistant must 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 (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician/Nurse Practitioner/Physician Assistant Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
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			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

Requirements for Completing the MOLST for Individuals with Intellectual or Developmental Disabilities

Completing the MOLST for individuals with I/DD who lack capacity to make their own health care decisions and do not have a health care proxy:

- The law governing the decision-making process differs for individuals with I/DD. Surrogate's Court Procedure Act (SCPA) Section 1750-b must be followed when making a decision for an individual with I/DD who lacks capacity and does not have a health care proxy.
- MOLST may only be signed by a **physician**, not a nurse practitioner or physician assistant.
- Completion of the **MOLST legal requirements checklist for individuals with I/DD**, including notification of certain parties and resolution of any objections, is **mandatory prior to completion of MOLST.** The checklist is available on the NYS OPWDD website.
- The checklist should be completed when an authorized surrogate makes a decision to **withhold or withdraw life sustaining treatment (LST)** from an individual with I/DD. There are specific medical criteria, included in Step 4 of the checklist. The individual's medical condition must meet the specified medical criteria **at the time the request to withhold or withdraw treatment is made.**
- **Trials** – whether or not a new checklist is required following an unsuccessful trial of LST depends on the parameters of the trial, as specified in Step 2 of the checklist. If Step 2 of the checklist has provided that a trial for LST is to end after a specific period of time or the occurrence of a specific event, it may not be necessary to complete a new checklist following the trial. However, if a trial period is open ended, and the authorized surrogate subsequently decides to request withdrawal of the LST, a new checklist would be required.
- The checklist and 1750-b process apply to individuals with I/DD, regardless of their age or residential setting.