OHIO Medical Orders for Life Sustaining Treatment Form Sec. 2133.31. (MOLST FORM)

This form must be reviewed at least yearly from the last signed date. DATE due for review: _____

HIPAA PERMITS DISCLOSURE OF THIS MOLST FORM TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY When signed, this form supersedes all previously signed MOLST forms. Comfort measures will be provided regardless of the intervention that is chosen.	Last Name/First/Middle Initial Date of Birth Last 4 SSN	Gender M F

A.CARDIOPULMONARY RESUSCITATION (CPR): Individual has no pulse and is not breathing. *Check only one:*

☐**Attempt Resuscitation/CPR.** Apply full treatment and intervention including intubation, advanced airway interventions, mechanical ventilation, defibrillation, and cardioversion as indicated. *Transfer to hospital or intensive care unit in a hospital, as applicable.*

☐**Do NOT Attempt Resuscitation (DNR; do not use CPR).**
When patient is not in cardiopulmonary arrest, follow orders in Sections B, and C.

B.MEDICAL INTERVENTIONS: Person has a pulse, is breathing, or both. *Check only one:*

☐**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. *Transfer to the appropriate level of care setting to provide comfort care measures.*
Additional Orders/Instructions: _____
_____

☐**Limited Additional Interventions.** Use all comfort measures described above. Use medical treatment, antibiotics, intravenous fluids, and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider alternative airway support (e.g., CPAP, BiPAP). *Transfer to hospital if indicated; generally avoid intensive care.*
*Additional Orders/Instructions:*_____
_____

☐**Full Intervention.** Use all comfort measures described above as well as limited medical interventions (described above) as indicated. Use intubation, advanced airway interventions, mechanical ventilation, defibrillation, and cardioversion as indicated. *Transfer to hospital and to intensive care if indicated.*
Additional Orders/Instructions: _____
_____

C.ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION:
The administration of nutrition or hydration, or both, whether orally or by medical means, shall occur except in the event that the patient is diagnosed with a terminal condition or is in a permanently unconscious state, as those terms are defined in Ohio Revised Code section 2133.01, and the administration of nutrition or hydration becomes a greater burden than benefit to the patient. **Always offer by mouth, if feasible. *Check only one:***

☐ Long-term artificial nutrition by tube feeding
☐ Defined trial period of artificial nutrition by tube feeding
☐ No artificial administered nutrition by tube feeding
Goals of Care / Additional order / instructions:

MOLST continued on the next page.

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Information for individual named on this form - Name:	DOB:

D. AUTHORIZATION NAME AND SIGNATURE BELONGS TO (CHECK ONLY ONE):

☐ Patient
☐ Guardian appointed by a probate court)
☐ Attorney in fact under patient's durable power of attorney for health care
☐ Next of Kin as specified in Ohio Revised Code section 2133.08(B)
- o Spouse
- o Majority of adult children (available within reasonable time)
- o Parents
- o Majority of adult siblings (available within reasonable time)
- o Other nearest related adult (available within reasonable time)

☐ Parent, Guardian, or Legal Custodian of a Minor

Authorized Individual (above) has reviewed the completed preferences in the following, as indicated, as a guide for this MOLST form and signs below:

☐ **Living Will**	**NO**	**YES - Attach Copy**
☐ **Health Care Power of Attorney**	**NO**	**YES - Attach Copy**

Name (printed): _____ **Phone Contact:** _____

Signature (mandatory): _____ **Date Signed:** _____

E. SIGNATURE OF ISSUING PRACTITIONER

My signature in this section indicates, to the best of my knowledge, that these orders are consistent with the patient's current medical condition and preferences as indicated by the patient's advance directives, previous discussions with the person identified in Section D., above, or both.

Name of Practitioner (printed): _____

Signature of Practitioner (mandatory): _____

Date Signed: _____ **License/Certificate #:** _____ **Phone #:** _____

F. SIGNATURE OF FORM PREPARER

Name of Form Preparer and Credentials (printed): _____ **Phone #:** _____

Signature of Form Preparer (mandatory): _____ **Date Signed:** _____

G. Review of MOLST

A MOLST form may be revoked at any time and in any manner that communicates the intent to revoke. A MOLST FORM expires on the date that is one year after the from was signed in accordance with the ORC sections 2133.34 and 2133.35.

Review of this MOLST FORM

Review Date And Time	Reviewer	Location of Review	Review Outcome
			☐ **No Change** ☐ **Voided and New form Completed**
			☐ **No Change** ☐ **Voided and New form Completed**
			☐ **No Change** ☐ **Voided and New form Completed**

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.

OHIO MOLST FORM INFORMATIONAL SUPPLIMENT

NOTICE TO ADULT NAMED ON THIS FORM:

The MOLST form is a medical order form that documents important health decisions regarding your health care. Your input and approval or the input and approval of your legal representative (i.e. an agent, guardian, next of kin, or legal custodian) concerning the form's use is needed before it becomes valid. The following is an information supplement to the MOLST form. Below signing the form after consulting with your health care practitioner, you should know the facts in this supplement.

Overview

The MOLST is not for everyone; and is always voluntary. It is only for an individual with a serious illness or frailty, for whom a health care professional would not be surprised if they died within one year.

The orders in the MOLST form are based on your medical condition, preferences, and advance directives (if any) at the time the orders are issued. Any incomplete section of the form does not invalidate the form and implies full treatment for the incomplete section. The form indicates your wishes for medical treatment in your current state of health. Once initial medical treatment has begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and the form can be modified at any time to reflect such changes. However, the form cannot address all medical treatment decisions that may need to be made. An advance directive, such as a living will (declaration) or durable power of attorney for health care, is recommended for all competent adults regardless of their health status. An advance directive allows you to document in detail your instructions for future health care and specify a health care "attorney-in-fact" or agent to speak on your behalf if necessary.

The duty of medicine is to care for you even when you cannot be cured. You will be treated with dignity and respect and attention will be given to your medical needs. Moral judgments about the use of technology to maintain life shall reflect the inherent dignity of human life, the duty of medical care, medical standards of practice, and your individual wishes. Use of the MOLST form recognizes the possibility of natural death. It does not authorize active euthanasia or physician-assisted suicide.

Implementation of the MOLST form

When signed, this form supersedes all previously signed MOLST forms. If a health care practitioner or facility cannot comply with the orders in the form due to policy or personal ethics, the practitioner or facility must arrange for your transfer to another practitioner or facility and provide the care you request until the transfer has been completed.

Review of MOLST form

This form must be reviewed not later than one year after it is signed and at least yearly thereafter. In additional, this form must be reviewed when you are transferred from one care setting or care level to another or there is a substantial change in your health status. A new MOLST form must be completed if you wish to make a substantive change to your treatment goals (e.g., reversal of a prior order). A MOLST form that you or your representative signed will be retained in your medical record pursuant to Ohio Revised Code section 2133.36.

Revocation of the MOLST form

This form may be revoked at any time and in any manner that communicates the intent to revoke. If you are under eighteen years of age, your parent, guardian, or legal custodian, may revoke a MOLST from at any time and in any manner that communicates the intent to revoke. A MOLST form that was revoked shall be retained in your medical record pursuant to Ohio Revised Code section 2133.38.

Portability of the MOLST form

This form must be sent with you when you are transferred between facilities or are discharged. Use of the original form is strongly encouraged, although photocopies and facsimiles are legal and valid. The HIPAA Privacy Rule permits disclosure of the form to health care professionals for treatment purposes.