

## Health Care Decision Making Worksheet

### Instructions

Use this worksheet either to indicate current treatment preferences (which will be reflected in Maryland MOLST orders) or to clarify wishes for future situations (which will be applied only when the issues become relevant in the future). Only initial those items for which a decision has been made or is needed. The remaining items can be left blank and may be completed later.

Although the choices on this worksheet represent wishes regarding various life-sustaining treatment options, this is not an order sheet or an advance directive.

For example, preferences about artificially administered fluids and nutrition would be incorporated into current orders if the individual currently has impaired nutrition or fluid/electrolyte balance that cannot be corrected by some other means. On the other hand, if the individual is eating or drinking adequately and related problems are not anticipated in the near future, then orders related to limiting these treatments may not need to be entered on the MOLST form. It may still be appropriate to do so if the individual has definitely decided about these treatments for the future.

Make one choice for cardiopulmonary resuscitation, by initialing the appropriate line. If no choice is made, resuscitation will be attempted by default. Choose one option for each of the other categories, as appropriate and desired, by initialing the appropriate line. Clarify specific care instructions, as needed.

Part A, Main goal(s) of care: Specific treatment preferences should reflect the main goal or goals of care. Part A invites the patient or the patient's authorized decision maker to identify goals. It allows for the identification of more than one main goal of care. Often, two goals can be pursued at the same time – for example, prolonging life while controlling pain and other distressing symptoms. But if the use of a life-sustaining treatment would be inconsistent with maximum comfort, as sometimes happens, then health care providers ought to know which goal is more important.

If the patient lacks capacity, the main goal(s) of care should be identified from the patient's perspective, based on the authorized decision maker's understanding of the patient's wishes, if known, or the patient's best interests. The authorized decision maker's personal beliefs and values should not override those of the patient, even if he or she is an appointed health care agent.

If there are multiple surrogate decision makers of equal authority involved in the preparation of the Health Care Decision Making Worksheet, they may not all agree on a life-sustaining treatment. Or, even if they agree, the attending physician may consider that the identified main goal of care is unrealistic or, if pursued, would result in burdens with little or no benefit for the patient. A health care provider should follow its customary procedures for addressing such conflicts, including, as appropriate, referral to the facility's patient care advisory (ethics) committee.

Part B, Advance directive and authorized decision maker contact information: The Health Care Decision Making Worksheet is not an advance directive or an order form. If a patient has already completed an advance directive, this worksheet could be attached to it. If the advance directive names a health care agent, contact information for the health care agent should be inserted. If there is no health care agent, contact information for the guardian or surrogate decision maker should be inserted. Even if the patient still has capacity, the contact information for whoever is to serve as health care proxy after loss of capacity should be included.



|    | Meaning and Implications   |
|----|--|
| 2  | <b>Artificial Ventilation:</b> What should be done for respiratory failure where cardiopulmonary arrest is not involved?   |
| 2a | _____ In case of respiratory failure (the individual cannot breathe adequately unaided), intubation and artificial ventilation may be initiated and continued for as long as breathing needs mechanical assistance, even indefinitely.   |
| 2b | _____ In case of respiratory failure, intubation and artificial ventilation may be initiated and continued for a limited time (time limit up to _____ days) to see if artificial ventilation is effective in light of a patient's overall condition and underlying causes of respiratory failure. During that trial period, reassess the situation to determine if continued use of artificial ventilation is warranted or if it should be discontinued. |
| 2c | _____ In case of respiratory failure, only CPAP or BiPAP may be used for artificial ventilation, as indicated, and continued for a limited time (time limit up to _____ days), to see if any of these interventions are effective and their continued use is pertinent in light of the patient's overall condition and underlying causes of respiratory failure. However, do not intubate or place on a ventilator.                                      |
| 2d | _____ Do not use artificial ventilation (i.e., no intubation, CPAP or BiPAP) under any circumstances.  |
| 3  | <b>Blood Transfusion:</b> Should blood transfusions or infusion of blood products be given in case of bleeding?  |
| 3a | _____ Blood and blood products (plasma, whole blood, and platelets) may be administered if indicated to replace or try to stop blood loss or to treat life-threatening anemia. This does not mandate transfusion for anemia or acute blood loss, regardless of medical indication, but authorizes it if it is medically indicated.   |
| 3b | _____ Do not give any blood transfusions or blood products.  |
| 4  | <b>Hospital Transfers:</b> Should hospital transfers occur to assess or treat medical conditions, and under what circumstances?  |
| 4a | _____ Transfer to the hospital is OK for any situation requiring medical care (i.e., if hospitalization is needed to diagnose, treat, or monitor the individual) that cannot be given outside of a hospital (This does not mandate automatic hospital transfer for any acute illness or change of condition, but only authorizes it if the situation cannot be addressed adequately outside of a hospital).  |
| 4b | _____ Hospital transfer may be used if necessary for comfort; to relieve distressing medical symptoms that cannot be managed elsewhere. Hospitalization should not be used primarily to try to identify, diagnose, and treat or cure underlying causes of symptoms.  |
| 4c | _____ Do not transfer to a hospital under any circumstances. Assess, treat, and monitor the patient with options available outside the hospital, as needed and consistent with patient goals.  |

|    | Meaning and Implications   |
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| 5  | <b>Medical Tests:</b> To what extent should medical tests be performed for diagnosis, treatment, and monitoring?   |
| 5a | _____ Any medical tests that are indicated to diagnose, treat, or monitor a patient may be obtained. This does not mandate medical tests, but authorizes testing if medically indicated.   |
| 5b | _____ Only perform limited medical tests necessary for symptomatic relief or comfort. Beyond that, it is acceptable to base any needed assessment, diagnosis, treatment, and monitoring on clinical findings instead of on diagnostic testing.   |
| 5c | _____ Do not do any medical tests. It is acceptable to base assessment, diagnosis, treatment, and monitoring on clinical findings instead of on diagnostic testing.  |
| 6  | <b>Antibiotics:</b> When should antibiotics be given, and how extensively?   |
| 6a | _____ Any antibiotics (oral, intravenous or intramuscular injection) that are medically indicated may be used, by any route of administration, to try to treat an infection. This does not mandate antibiotics, but authorizes their use if medically indicated.   |
| 6b | _____ Oral antibiotics may be used, if medically indicated, on a limited basis and not indefinitely, to treat an infection. Intravenous or intramuscular antibiotics should not be used.   |
| 6c | _____ Antibiotics should only be used if needed to try to relieve symptoms for comfort, and should only be given orally, and not with the primary goal of trying to cure an infection.   |
| 6d | _____ Do not give antibiotics. In case of an infection, give only symptomatic treatment, such as medicines for fever or pain relief.   |
| 7  | <b>Artificially administered fluids and nutrition:</b> Under what circumstances, and to what extent, should artificially administered fluids and nutrition be given?   |
| 7a | _____ Artificially administered fluids and nutrition may be given, even indefinitely, if indicated, by any available means. This does not mandate giving these interventions regardless of lack of a medical indication. It recognizes that medical treatment may address treatable causes of weight loss and fluid imbalances.  |
| 7b | _____ Artificially administered fluids and nutrition may be administered, if indicated, as a therapeutic trial for a limited time (time limit: up to _____ days). During that trial period, reassessment will be done to determine if continued use of these interventions is indicated and desired or if it should be discontinued. For example, because underlying causes of weight loss cannot be corrected. Artificially administered fluids and nutrition may also be administered for palliation, if consistent with the patient's goals and wishes. |
| 7c | _____ Artificially administered hydration (intravenous or subcutaneous fluids or PEG tube) may be given, but not artificial nutrition.   |
| 7d | _____ No artificially administered fluids and nutrition will be give. Offer food and fluids by mouth as desired and tolerated.   |

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| 8  | <b>Kidney Dialysis:</b> Should dialysis be used if the kidneys do not function adequately, and under what circumstances?  |
| 8a | _____ Dialysis (either hemodialysis or peritoneal) may be given, even indefinitely, for any medical indication related to inadequate kidney function including end-stage kidney disease.  |
| 8b | _____ Dialysis (either hemodialysis or peritoneal) may be administered, but only for a limited period (time limit: up to _____ days), until prognosis is determined, etc.), to see if dialysis is effective and pertinent in light of the overall situation. This does not mandate giving dialysis regardless of lack of a medical indication, but authorizes its use if medically appropriate. |
| 8c | _____ No dialysis of any type or duration should be provided.   |
| 9  | <b>Other Treatments:</b> Are there any other instructions related to life-sustaining treatments not otherwise covered in Sections 1-8 above?<br><br>_____   |

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| _____   |       |
| Print patient's name  |       |
| _____   |       |
| Signature of patient  | _____ |
|   | Date  |
| _____   |       |
| Print name of authorized decision maker   |       |
| <input type="checkbox"/> Health Care Proxy, <input type="checkbox"/> Guardian, or <input type="checkbox"/> Surrogate Decision Maker | _____ |
|   | Phone |
| _____   |       |
| Signature of authorized decision maker  | _____ |
|   | Date  |
| _____   |       |
| Print name of health care provider assisting with form  | _____ |
|   | Phone |
| _____   |       |
| Signature of health care provider assisting with form   | _____ |
|   | Date  |
| _____   |       |
| Print name of patient's physician or nurse practitioner   | _____ |
|   | Phone |
| _____   |       |
| Signature of patient's physician or nurse practitioner  | _____ |
|   | Date  |



# Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial

Date of Birth

 Male     Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

## CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

- the patient; or  
 the patient's health care agent as named in the patient's advance directive; or  
 the patient's guardian of the person as per the authority granted by a court order; or  
 the patient's surrogate as per the authority granted by the Health Care Decisions Act; or  
 if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

- instructions in the patient's advance directive; or  
 other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

- Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

**CPR (RESUSCITATION) STATUS:** EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

**Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.  
 [If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

**1 No CPR, Option A, Comprehensive Efforts to Prevent Arrest:** Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

**Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

**Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

**No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

## SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature

Print Practitioner's Name

Maryland License #

Phone Number

Date

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

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| <b>2</b> | <b>ARTIFICIAL VENTILATION</b><br>2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.<br>2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.<br>Time limit _____<br>2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.<br>Time limit _____<br>2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP). |
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| <b>3</b> | <b>BLOOD TRANSFUSION</b><br>3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated. |  | 3b. _____ Do not give any blood products. |
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| <b>4</b> | <b>HOSPITAL TRANSFER</b><br>4a. _____ Transfer to hospital for any situation requiring hospital-level care. |  | 4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.<br>4c. _____ Do not transfer to hospital, but treat with options available outside the hospital. |
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| <b>5</b> | <b>MEDICAL WORKUP</b><br>5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition. |  | 5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.<br>5c. _____ Do not perform any medical tests for diagnosis or treatment. |
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| <b>6</b> | <b>ANTIBIOTICS</b><br>6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.<br>6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics. |  | 6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.<br>6d. _____ Do not treat with antibiotics. |
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| <b>7</b> | <b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION</b><br>7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.<br>7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.<br>Time limit _____ |  | 7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.<br>Time limit _____<br>7d. _____ Do not provide artificially administered fluids or nutrition. |
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| <b>8</b> | <b>DIALYSIS</b><br>8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated. |  | 8b. _____ May give dialysis for a limited period.<br>Time limit _____<br>8c. _____ Do not provide acute or chronic dialysis. |
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| <b>9</b> | <b>OTHER ORDERS</b> _____<br>_____<br>_____<br>_____ |
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| <b>SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)</b> |                           |      |
| Practitioner's Signature  | Print Practitioner's Name |      |
| Maryland License #  | Phone Number              | Date |



## INSTRUCTIONS

**Completing the Form:** The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician, NP, or PA signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

**Selecting CPR (Resuscitation) Status:** EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

**No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option.** Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers*. Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

**No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR.** Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

**Location of Form:** The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

**Reviewing the Form:** These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians, NPs, or PAs shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

**Updating the Form:** The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form.

**Voiding the Form:** To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

**Revoking the Form's DNR Order:** In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

**Bracelets and Necklaces:** If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

**How to Obtain This Form:** Call 410-706-4367 or go to [marylandmolst.org](http://marylandmolst.org)



Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician, NP, or PA sign, cut off strip, fold, and insert in bracelet or necklace.

DNR A-1 Intubate     DNR A-2 Do Not Intubate     DNR B

Pt. Name \_\_\_\_\_ DOB \_\_\_\_\_

Practitioner Name \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Phone \_\_\_\_\_