This form is yours to keep with you.
Bring it to all medical appointments and admissions to health care facilities.

Connecticut
Medical Orders for Life Sustaining Treatment (MOLST)
PILOT PROGRAM

PATIENT INFORMATION

Patient Last Name/First/Middle Initial		
Street	City/Town	ZIP
Date of Birth (mm/dd/yyyy)	Sex: M [ ] F [ ]	

ELIGIBLE DIAGNOSIS:
[ ] END STAGE SERIOUS, LIFE LIMITING ILLNESS: (specify)_____ OR
[ ] ADVANCED CHRONIC PROGRESSIVE FRAILTY CONDITION:

GOALS OF TREATMENT- MEDICAL INTERVENTIONS: (check one box only)
[ ] a. No limitations to medical treatment & intervention
[ ] b. Limited medical treatment or intervention
[ ] c. Comfort care; allow natural death with symptom management for comfort purposes

Section A (Check one box only)

CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING

[ ] Perform CPR [ ] Do Not Perform CPR

If patient is not in cardiopulmonary arrest, follow orders in section B & C.

Section B (Check one box only)

Transfer to Hospital

[ ] Transfer to hospital [ ] ICU care [ ] No ICU care	[ ] Do not transfer to hospital (unless needed for my comfort)

Intubation and Ventilation (Non CPR related)

[ ] Use invasive airway management or mechanical ventilation [ ] Use invasive airway management or mechanical ventilation, defined trial period Length of trial period: _____	[ ] No invasive airway management or mechanical ventilation

Non-Invasive Ventilation

[ ] Use non-invasive ventilation or rescue breathing for respiratory distress, such as BiPAP or CPAP [ ] Use non-invasive ventilation defined trial period Length of trial period: _____	[ ] Do not use non-invasive ventilation

HIPAA PERMITS DISCLOSURE OF MOLST TO ANY HEALTH CARE PROFESSIONAL AS NEEDED FOR PATIENT CARE

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Section C (Check one box only)

Medically Administered Hydration (oral or by mouth hydration will always be offered if feasible)

[ ] Use medically administered hydration [ ] Use medically administered hydration, defined trial period Length of trial period: ______________	[ ] No medically administered hydration	[ ] Undecided [ ] Did not discuss

Medically Administered Nutrition (oral or by mouth nutrition will always be offered if feasible)

[ ] Use medically administered nutrition, such as total parenteral nutrition or tube feedings [ ] Use medically administered nutrition defined trial period Length of trial period: ______________	[ ] No medically administered nutrition	[ ] Undecided [ ] Did not discuss

Dialysis

[ ] Use dialysis [ ] Use dialysis, defined trial period Length of trial period: ______________	[ ] No dialysis	[ ] Undecided [ ] Did not discuss

Other treatment preferences specific to the patient's medical condition, e.g. vasopressors, medications, antibiotics, etc.

Section D

For this form to be valid: The form must be a lime green original MOLST form and the provider signing must ensure the form is thoroughly completed and signed by the patient or patient's legally authorized representative, provider and witness. A form that is incomplete, improperly completed or amended, except as permitted in Section E shall be deemed invalid and of no effect.

Discussed with:

[ ] Patient

[ ] Legally Authorized Representative (specify) ______________________

Signature below confirms this form was signed by the patient or Legally Authorized Representative **voluntarily** and reflects his/her wishes and goals of treatment as expressed to the provider signing below. Signature by a patient representative as indicated above confirms the form reflects his/her assessment of the patient's preferences or goals of care, or if those preferences are unknown, his/her understanding of the patient's best interests.

Signature of Patient or Legally Authorized Representative:	Date:
Printed Name of Patient or Legally Authorized Representative:	
Signature of Provider: [ ] MD/DO [ ] APRN [ ] PA	
Printed Name of Provider:	Date:
Provider Phone Number:	
Signature of Witness:	
Printed Name of Witness:	Date:
Interpreter Name or ID# and/or Service	Date:

Section E
Review of this MOLST form

Date of Review	Provider Signature	Printed Name	Credentials	Reviewed With	Location of Review	Outcome of Review
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form

Review of MOLST Form

This form should be reviewed upon transfer of a patient to a hospital or other health care facility, or if there is a substantial change in the patient's health status or treatment preferences. 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 on the front of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided.

Additional Instructions For Health Care Professionals

THIS FORM IS VOLUNTARY FOR THE PATIENT

Follow orders listed in section A, B and C until there is an opportunity for the clinician to review the form with the patient or the legally authorized representative (when the patient lacks capacity).

The patient or legally authorized representative (if the patient lacks capacity) can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment .

If the patient or legally authorized representative elects short term use of a medical intervention then the trial period **MUST** be filled in on the form.

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