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 Heath 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.

1

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.]

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

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 ☐ Male ☐ Female

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.

2 ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 BLOOD TRANSFUSION

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.

4 HOSPITAL TRANSFER

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.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 MEDICAL WORKUP

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.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

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.

6d. _____ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

9 OTHER ORDERS _____

_____

_____

_____

_____

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

RESIDENT ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation.
An exception is provided for residents who are under the care of a licensed general hospice program.

Resident: _____ DOB: _____ Assessment Date: _____

Primary Spoken Language: _____ ☐ Male ☐ Female

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.

Test to verify the resident is free from active TB *(completed no more than 1 year prior to admission)*:

PPD Date: _____ Result: _____ mm OR Chest X-Ray Date: _____ Result: _____

Does the resident have any active reportable airborne communicable diseases? ☐ No ☐ Yes

(specify)

Vital Signs.

BP:_____/_____ Pulse:_____ Resp:____ T:_____°F Height:____ft____in Weight:_____lbs

Pain? ☐ No ☐ Yes (specify site, cause, & treatment)

Resident: _____ DOB: _____ Assessment Date: _____

Neuro. Alert & oriented to: ☐ Person ☐ Place ☐ Time

Answers questions: ☐ Readily ☐ Slowly ☐ Inappropriately ☐ No Response

Memory: ☐ Adequate ☐ Forgetful - needs reminders ☐ Significant loss - must be directed

Is there evidence of dementia? ☐ No ☐ Yes (cause) _____

Cognitive status exam completed? ☐ No ☐ Yes (results) _____

Sensation: ☐ Intact ☐ Diminished/absent (describe below)

Sleep aids: ☐ No ☐ Yes (describe below) Seizures: ☐ No ☐ Yes (describe below)

Comments:

Eyes, Ears, & Throat. ☐ Own teeth ☐ Dentures Dental hygiene: ☐ Good ☐ Fair ☐ Poor

Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind - ☐ R ☐ L

Hearing: ☐ Adequate ☐ Poor ☐ Uses corrective aid ☐ Deaf - ☐ R ☐ L

Comments:

Musculoskeletal. ROM: ☐ Full ☐ Limited

Mobility: ☐ Normal ☐ Impaired → Assistive devices: ☐ No ☐ Yes (describe below)

Motor development: ☐ Head control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors

ADLs: (S=self; A=assist; T=total) Eating: ___ Bathing: ___ Dressing: ___

Is the resident at an increased risk of falling or injury? ☐ No ☐ Yes (explain below)

Comments:

Skin. Intact: ☐ Yes ☐ No (if no, a wound assessment **must** be completed)

☐ Normal ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other

Any skin conditions requiring treatment or monitoring? ☐ No ☐ Yes (describe condition & treatment)

Comments:

Respiratory. Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored

Breath sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)

Shortness of breath: ☐ No ☐ Yes (indicate triggers below)

Respiratory treatments: ☐ None ☐ Oxygen ☐ Aerosol/nebulizer ☐ CPAP/BIPAP

Comments:

Circulatory. History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension

Pulse: ☐ Regular ☐ Irregular Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes

Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic

Comments:

Resident: _____ DOB: _____ Assessment Date: _____

Diet/Nutrition. ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets

☐ Mechanical soft ☐ Pureed ☐ Other _____ ☐ Supplements _____

Is there any condition which may impair chewing, eating, or swallowing? ☐ No ☐ Yes (explain below)

Is there evidence of or a risk for malnutrition or dehydration? ☐ No ☐ Yes (explain below)

Is any nutritional/fluid monitoring necessary? ☐ No ☐ Yes (describe type/frequency below)

Are assistive devices needed? ☐ No ☐ Yes (explain below)

Mucous membranes: ☐ Moist ☐ Dry Skin turgor: ☐ Good ☐ Fair ☐ Poor

Comments:

Elimination.

Bowel sounds present: ☐ Yes ☐ No Constipation: ☐ No ☐ Yes Ostomies: ☐ No ☐ Yes

Bladder: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence

Bowel: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence

(If any incontinence, describe management techniques)

Comments:

Additional Services Required. ☐ No ☐ Yes (indicate type, frequency, & reason)

☐ Physical therapy ☐ Home health ☐ Private duty ☐ Hospice ☐ Nursing home care ☐ Other

Comments:

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? ☐ No ☐ Yes (explain)

Comments:

Psychosocial. **KEY:** **N** = *Never* **O** = *Occasional* **R** = *Regular* **C** = *Continuous*

	N	O	R	C	Comments
Receptive/Expressive Aphasia					
Wanders					
Depressed					
Anxious					
Agitated					
Disturbed Sleep					

Resident: _____ DOB: _____ Assessment Date: _____

Psychosocial.	**KEY:** **N** = *Never*	**O** = *Occasional*	**R** = *Regular*	**C** = *Continuous*	
	N	**O**	**R**	**C**	**Comments**
Resists Care					
Disruptive Behavior					
Impaired Judgment					
Unsafe Behaviors					
Hallucinations					
Delusions					
Aggression					
Dangerous to Self or Others					*(if response is anything other than never, explain)*

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: ☐ Yes ☐ No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:

☐ Probably can make higher level decisions *(such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, & risks of proposed treatment)*
☐ Probably can make limited decisions that require simple understanding
☐ Probably can express agreement with decisions proposed by someone else
☐ Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:

☐ Independently without assistance
☐ Can do so with physical assistance, reminders, or supervision only
☐ Needs to have medications administered by someone else

General Comments.

Health Care Practitioner's Signature: _____ Date: _____

Print Name & Title: _____

Resident: _____ DOB: _____ Assessment Date: _____

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? ☐ Yes ☐ No (explain below)

Were any discrepancies identified? ☐ No ☐ Yes (explain below)

Are medications stored appropriately? ☐ Yes ☐ No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below)

Have arrangements been made to obtain ordered labs? ☐ Yes ☐ No (explain below)

Is the resident taking any high risk drugs? ☐ No ☐ Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below) ☐ N/A

Is the environment safe for the resident? ☐ Yes ☐ No (explain below)

(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: _____

Print Name: _____

Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.

***Six-Month Review** Conducted By:*

Signature: _____ *Date:* _____

Print Name & Title: _____

Resident: _____ DOB: _____ Date Completed: _____

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all): _____

MEDICATIONS & TREATMENTS:

List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

Medication/Treatment Name	*Dose*	*Route*	*Frequency*	*Reason for Giving*	*Related Monitoring & Testing (if any)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Resident: _____ DOB: _____ Date Completed: _____

17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

Lab Test	*Reason*	*Frequency*
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders? _____

Prescriber's Signature: _____ Date: _____

Office Address: _____ Phone: _____