

# 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 of 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

Patient's Last Name, First, Middle Initial	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
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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.

<b>2</b>	<b>ARTIFICIAL VENTILATION</b> 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).
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<b>3</b>	<b>BLOOD TRANSFUSION</b> 3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated. <span style="float: right; padding-left: 100px;">3b. _____ Do not give any blood products.</span>
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<b>4</b>	<b>HOSPITAL TRANSFER</b> 4a. _____ Transfer to hospital for any situation requiring hospital-level care. <span style="float: right; padding-left: 100px;">4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.</span> <span style="float: right; padding-left: 100px;">4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.</span>
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<b>5</b>	<b>MEDICAL WORKUP</b> 5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition. <span style="float: right; padding-left: 100px;">5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.</span> <span style="float: right; padding-left: 100px;">5c. _____ Do not perform any medical tests for diagnosis or treatment.</span>
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<b>6</b>	<b>ANTIBIOTICS</b> 6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated. <span style="float: right; padding-left: 100px;">6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.</span> 6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics. <span style="float: right; padding-left: 100px;">6d. _____ Do not treat with antibiotics.</span>
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<b>7</b>	<b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION</b> 7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated. <span style="float: right; padding-left: 100px;">7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.</span> 7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial. <span style="float: right; padding-left: 100px;">Time limit _____</span> <span style="float: right; padding-left: 100px;">7d. _____ Do not provide artificially administered fluids or nutrition.</span>
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<b>8</b>	<b>DIALYSIS</b> 8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated. <span style="float: right; padding-left: 100px;">8b. _____ May give dialysis for a limited period.</span> <span style="float: right; padding-left: 100px;">Time limit _____</span> <span style="float: right; padding-left: 100px;">8c. _____ Do not provide acute or chronic dialysis.</span>
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<b>9</b>	<b>OTHER ORDERS</b> _____ _____ _____ _____ _____
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**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