HealthCare Partners, IPA

Advance Care Planning

Making Your Health Care Wishes Known

The Time to Act is **NOW**

The enclosed information is meant to help you plan for the future. It is not meant to give you legal advice. If you have a specific question or problem relating to your health care wishes, speak to a medical or legal professional.

Advance Care Planning: Important Points

Advance Directives are for everyone, not just the elderly and the chronically ill.

Advance Directives can help you ensure that your health care wishes are followed if you are unable to make decisions for yourself.

You can cancel or update your Advance Directives at any time.

Consider carrying a wallet card containing information about your Health Care Proxy.

It's your decision to accept or reject medical treatment. Your health care treatment is based on your personal wishes, values and beliefs.

Advance Directives work best when accompanied by discussions with your family and loved ones about your personal values and beliefs. You may also wish to speak with a patient representative, your doctor or lawyer.

Resources

New York State Department of Health

Call or go online to obtain a Health Care Proxy form with instructions in English, Chinese, Haitian, Creole, Italian, Korean, Russian or Spanish.

Call: **1 (800) 628-5972** or visit: **www.health.ny.gov**

National Hospice & Palliative Care Organization

Visit **www.caringinfo.org** for free resources to help people make decisions about end-of-life care.

Out-of-State Advance Care Planning

Advance Care Planning (ACP) laws vary state by state. It is important to visit each state's Department of Health website to understand their individual Health Care Proxy forms, Living Wills and DNR Order requirements.

Advance Care Planning: What You Should Know

How It Works

Advance Care Planning (ACP) is a process of planning for future medical care in case you are unable to make your own medical decisions. It assists you in preparing for a sudden unexpected illness or accident, from which you may or may not recover.

ACP permits peace of mind for you and your family by reducing uncertainty and helping to avoid confusion and conflict over your medical care.

It allows you to maintain control over how you are treated and ensures that you experience the type of care you desire – now and in the future.

Advance Care Planning is not just for the elderly.

There are times when people – even young, healthy people – can't make their own decisions about medical care:

- You could be injured in an accident and arrive at the hospital unconscious
- You might be under general anesthesia for routine surgery when something unexpected happens
- You could have an illness that leaves you comatose or unable to speak

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indicates form to be filled out and detached

How to Maintain Control & Share Your Wishes with Advance Directives

There are three legal documents known as **Advance Directives** that can be completed to ensure your health care wishes are followed. **Once these forms have been filled in and properly signed, they become valid under New York law.**

The Three Advance Directive Documents:		
New York State Health Care Proxy	**Living Will**	**Do Not Resuscitate (DNR) Order** (for those who are seriously ill)
What it does: Lets you name a health care agent who will make decisions on your behalf if you cannot make them yourself.	**What it does:** Lets you explain your health care wishes, especially about end-of-life care. It can be an important source of guidance for your health care agent.	**What it does:** Tells health care providers and emergency workers not to revive you if you stop breathing or your heart stops beating.
When it takes effect: After two doctors decide you are not able to make your own decisions.	**When it takes effect:** Once you cannot make your own decisions and your doctor confirms that you have an incurable condition.	**When it takes effect:** When signed by your doctor. A DNR is arranged with your doctor or health care provider before an emergency occurs.
Standard New York State form? Yes. *Health Care Proxy is attached for your convenience.*	**Standard New York State form?** No. *Living Will is attached for your convenience.*	**Standard New York State form?** Yes. *Your physician must complete at your request.*

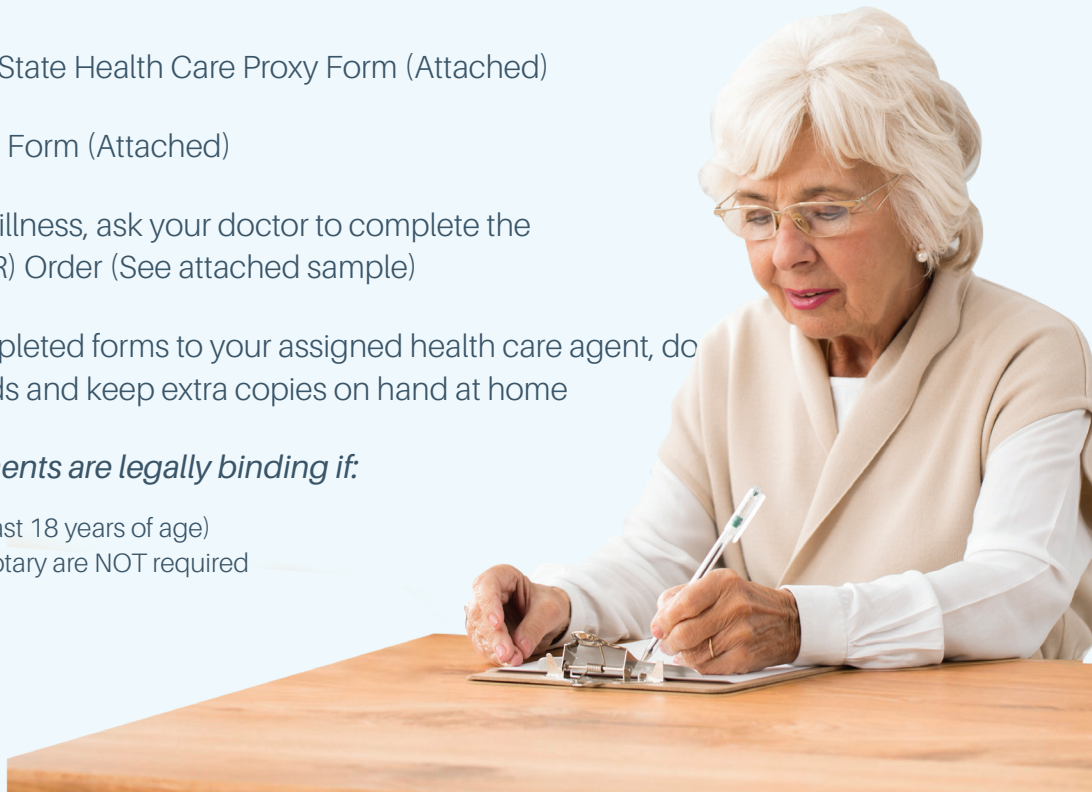
Remember: Directives only apply when the need arises and you are unable to make your own medical decisions.

Ensure Your Health Care Wishes are Fulfilled

Advance Care Planning offers you peace of mind by reducing uncertainty and helping to avoid confusion and conflict over your medical care.

Here are some steps you can take to ensure your wishes are clear:

- Complete the New York State Health Care Proxy Form (Attached)
- Complete the Living Will Form (Attached)
- If you have an incurable illness, ask your doctor to complete the Do Not Resuscitate (DNR) Order (See attached sample)
- Give copies of your completed forms to your assigned health care agent, do family members or friends and keep extra copies on hand at home



Understand that these documents are legally binding if:

- You are a competent adult (at least 18 years of age) during completion (Lawyer or notary are NOT required to fill out these forms)
- Documents are properly signed, witnessed and dated

If you do not wish to be hospitalized:

Whether at home, in an assisted living facility, inpatient skilled nursing or hospice facility, you will need to ask your doctor to write a "Do Not Hospitalize" order to be added to your medical record.

DNR Alert Bracelets & Necklaces:

Medic Alert Foundation International can issue DNR bracelets and necklaces provided they have a copy of your New York DNR form (DOH-3474) on file. You can have a valid non-hospital DNR order without wearing a DNR bracelet – the bracelet is purely voluntary.

Medic Alert (888) 633-4298

The New York State Health Care Proxy

The Health Care Proxy is especially useful because it lets you appoint someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life. This individual — known as your Health Care Agent — will decide on your medical care, including whether to remove or provide life-sustaining treatment.

Unlike a Living Will, a Health Care Proxy does not require that you make decisions regarding specific medical treatment that may become necessary in the future.

Step 1. Understand the Amount of Authority to Assign to Your Health Care Agent

You can give your Health Care Agent as much or little authority as you want along with the ability to make all – or specific – health care decisions. **If you choose not to list specifics, you can simply state, "My agent knows my wishes." Unless specified, your agent will be given broad authority to act in your best interest in regards to your medical treatment and care**.

Step 2. Your Health Care Agent and Alternate

Your Health Care Agent should be someone you trust and who knows you well. Whether you select a spouse, family member, or friend, talk to them about your wishes and get their agreement to respect and follow them. This person will assure that your wishes, values and beliefs are carried out. In addition, choose the right alternate spokesperson to substitute if your primary is unable or unavailable.

Your Health Care Agent & Alternate Should:

- ✓ Live nearby so available as needed (if possible)
- ✓ Be at least 18 years or older
- ✗ Not be your health care provider, the owner, operator or employee of a health, residential or community care facility serving you

Step 3. Complete & Sign Your Health Care Proxy

Follow the detailed instructions on the following page. Special instructions (optional) can be included to limit your agent's authority. Examples include whether or not you want life support or under what circumstances artificial nutrition and hydration would be acceptable. Organ and/or tissue donation (optional) can also be specified on the form.

Make sure your Health Care Proxy meets the minimum requirements:

- Your name as the person creating the Health Care Proxy
- Name of your Health Care Agent
- Statement that your agent can make health care decisions on your behalf
- You must sign and date the proxy with two witnesses present; if unable to sign, you can request another adult to sign your proxy for you

Step 4. After Your Health Care Proxy is Completed

Once you and two witnesses have signed the Health Care Proxy (and optional wallet card), your wishes will be legal and valid. Your final steps in the process include:

Review your wishes with your Health Care Agent, family and others you wish to include. Provide them with a copy of your proxy.

Keep the original signed copy in a safe place in your home. Inform your agent/family members where it can be found if needed.

Give your doctor a copy and have it placed in your medical record. Be sure your doctor understands and is willing to follow your wishes.

If admitted to a hospital or nursing home, bring a copy of your Health Care Proxy and ask that it be placed in your medical record.

Review and update as needed: Major life events like divorce, birth of a child or death of a spouse may require the completion of new documents. You may also decide to reevaluate your wishes if new life-threatening or chronic illnesses develop. New copies should be provided to the appropriate parties with instructions to destroy the previous version.

If you change your mind, you may revoke your proxy by notifying your agent or health care provider orally or in writing. Remember to destroy previous version(s).

Enjoy the peace of mind in knowing that your health care wishes have been captured and will be carried out.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and/or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

Cut here

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health

Cut here

Health Care Proxy Wallet Card

Fill out, print and keep this card in your wallet for added peace of mind

See directions for use on back →

Health Care Proxy Wallet Card

HealthCare Partners, IPA

Fold

Fold

This proxy was signed in my presence. The signer is known to me and appears to be of sound mind and to act of his/her own free will.

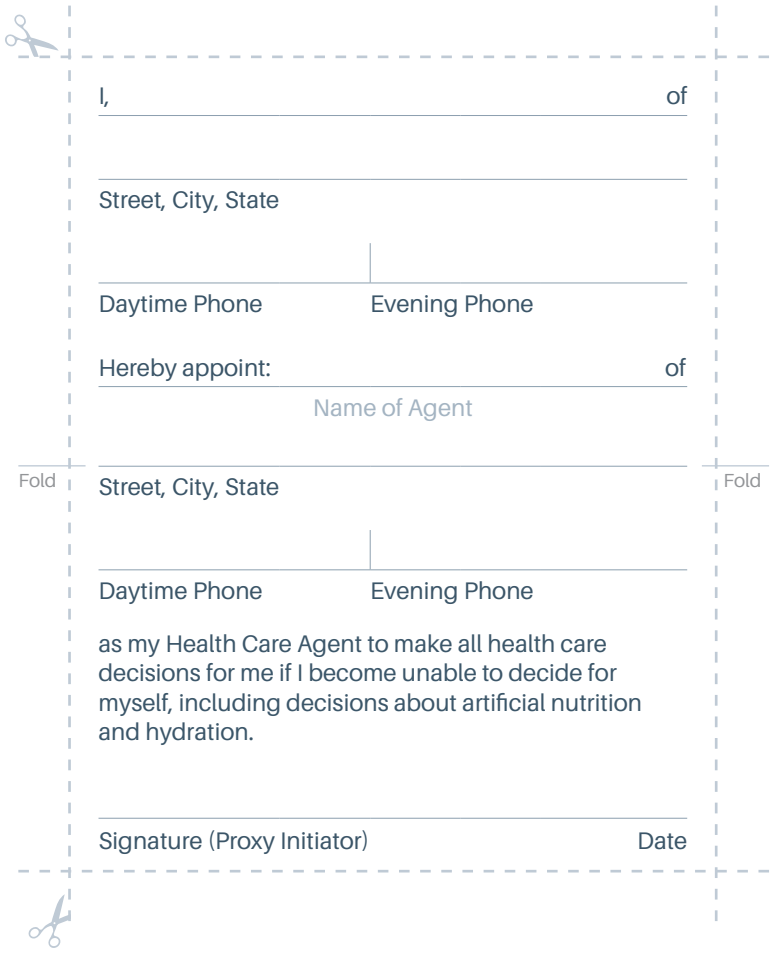
Signature (Witness) Date

Signature (Witness) Date

Health Care Proxy Wallet Card

To use this Wallet Card:

1. Simply remove the card by cutting along the dotted line.
2. Fill out the card so that it includes the identical information contained within your New York Health Care Proxy Form.
3. Have the card properly witnessed by two individuals as you did with the New York Health Care Proxy Form.
4. Carry this wallet card along with your state issued identification and insurance card.
5. Enjoy the peace of mind knowing that your spokesperson can be contacted and your wishes discussed even if something happens to you when your New York Health Care Proxy Form is not immediately accessible.



The New York Living Will Document

A Living Will is a document used to capture your detailed wishes about end-of-life care. It serves to provide additional guidance to your Health Care Agent, Alternate, family and friends.

Step 1. Write Your Living Will

In your Living Will, you can outline the medical situations in which you would accept or refuse medical treatment. For example, you could specify whether you wish to be kept alive with a feeding tube or intravenous feeding if you are terminally ill or comatose and there is no hope you will recover. Your Living Will also allows you to record preferred pain relief, organ donation, and other advance planning.

Step 2. Sign Your Living Will

Make sure your Living Will meets the minimum requirements:

- Your name as the person creating the Living Will
- Your statement regarding your personal health care wishes
- You must sign and date the Living Will with two witnesses present; if unable to sign, you can request another adult to sign your Living Will for you

To address health care in regards to mental illness:
Speak to your physician and an attorney about a durable power of attorney tailored to your needs, since the Living Will does not expressly cover mental illness.

Step 3. After Your Living Will Has Been Completed

Once you and two witnesses have signed the Living Will, your wishes will be legal and valid. Your final steps in the process include:

Review your wishes with your Health Care Agent, family and others you wish to include. Provide them with a copy of your Living Will.

Keep the original signed copy in a safe place in your home. Inform your agent/family members where it can be found if needed.

Give your doctor a copy and have it placed in your medical record. Be sure your doctor understands and is willing to follow your wishes.

If admitted to a hospital or nursing home, bring a copy of your Living Will and ask that it be placed in your medical record.

Review and update as needed: Major life events like divorce, birth of a child or death of a spouse may require the completion of new documents. You may also decide to reevaluate your wishes if new life-threatening or chronic illnesses develop. New copies should be provided to the appropriate parties with instructions to destroy the previous version.

If you change your mind, you may revoke your proxy by notifying your agent or health care provider orally or in writing. Remember to destroy previous version(s).

To address issues not covered in the Living Will form

Once you and two witnesses have signed the Living Will, your wishes will be legal and valid. Your final steps in the process include:

- **Consider consulting a lawyer regarding specific requests** — such as CPR, blood transfusions and dialysis, or whether you want to be kept alive on machines for a short time if necessary to be an organ donor. A custom-tailored Living Will can help make clear your objection to unwanted medical treatments.
- **To address health care in regards to mental illness** — speak to your physician and an attorney about a durable power of attorney tailored to your needs, since the Living Will does not expressly cover mental illness.
- **If you have questions** — discuss them with your doctor, a patient representative at a hospital, or a lawyer.

This is an important legal document. Read it carefully and talk about it with your doctor and family. It directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and are terminally ill, in a permanently unconscious condition, or in a minimally conscious condition in which you are permanently unable to make decisions or express your wishes.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

Health Care:
If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes, it is my wish that the following directions be followed by my health care provider.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

Directions: For each choice below: 1) Cross out any of these that you do want AND 2) write your initials next to any statement with which you agree:

_____ I do not want Cardiopulmonary Resuscitation (CPR), and I want my health care provider to issue a Do Not Resuscitate (DNR) order (an order written in my medical records that CPR is not to be administered to me).

_____ I do not want mechanical respiration.

_____ I do not want artificial nutrition and/or hydration (provision of foods and fluids through tubes).

_____ I do not want antibiotics.

_____ I do not want dialysis-cleaning the blood by machine

_____ I do not want blood transfusions/blood products

_____ I do not want invasive diagnostic tests - flexible tube to look into the stomach

_____ I do not want anti-psychotic medication

_____ I do not want electric shock therapy

_____ I do not want transplantation

_____ I do not want abortion / sterilization

_____ I do not want a pacemaker (non-cardiac related terminal or irreversible condition)

_____ I do not want surgery (you can define what surgery you do not want.)

_____ I do not want any other painful or invasive treatment that will result in prolonging my life.

_____ I DO want maximum pain relief, even if it may hasten my demise.

Other Instructions or Comments about My Care:

_____

_____

_____

_____

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed _____ Date _____

Address_____

Witnesses: Two witnesses must be 18 years of age or older and cannot be the health care agent or alternate.

I declare that the person who signed this document appeared to execute the Living Will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:

Print Name: _____

Signature: _____

Address: _____

Tel. No.: _____

Witness 2:

Print Name: _____

Signature: _____

Address: _____

Tel. No.: _____

Optional: Organ and/or Tissue Donation

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

I hereby make an anatomical gift, to be effective upon my death, of (*write your initials next to the statement of your choice*):

_____ Any organs and/or tissues

_____ The following organs and/or tissues:

_____

_____

Limitations:

_____

_____

If you do not state your wishes or instructions regarding organ and/or tissue donation on this form, it will not mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Signed _____ Date: _____

Address: _____

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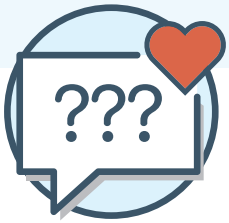

New York Health Care Proxy & Living Will Frequently Asked Questions

Q: Why should I choose a Health Care Agent/spokesperson?

A: If you become unable, even temporarily, to make health care decisions, someone else must make them for you. Health care providers often look to family members for guidance. Appointing an agent lets you control your medical treatment by choosing a friend or family member that will honor your wishes and make the best decisions on your behalf based on your beliefs, values and conversations. This will help to avoid conflict or confusion. You may also choose to appoint an alternate agent in case your first choice is not available.

Q: How can I be sure that my Health Care Proxy and Living Will are going to be honored?

A: In addition to selecting an agent that you trust and who knows you well and understands your wishes, your proxy and Living Will must be signed and dated in the presence of two adult witnesses, thus making it legally binding. The witnesses are confirming that you signed the documents willingly and free from duress. By giving your Health Care Agent authority to make health care decisions on your behalf, you can be assured that your wishes will be honored.

Q: Do I need to complete both the Health Care Proxy and Living Will?

A: To help ensure that you receive the medical care you desire, both documents should be competed. However, you should continue to have ongoing discussions with your Health Care Agent/spokesperson to assure he/she knows your values and wishes and can speak on your behalf regardless of what your circumstances may be.

Q: Can I add personal instructions to my Living Will?

A: Yes – personal instructions may be added to the section titled "Other Directions" and may include specific treatments you wish to refuse or accept including requests to:

- Receive the maximum amount of pain medication
- Die at home as opposed to being placed in a nursing home
- Use your spokesperson to clarify requests made in your Living Will

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Q: If I live in or spend extended periods of time in another state, will my New York State Proxy and Living Will be honored?

A: Visit the state-specific Department of Health website to learn its laws. Or visit caringinfo.org to find Advance Directives from other states.

Do Not Resuscitate Order (DNR) – For those who are seriously ill

A DNR is a medical order written by a doctor instructing health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. It is created before an emergency occurs and is specific to CPR. It does not have instructions for other treatments, such as pain medicine or nutrition.

The doctor writes the order only after talking about it with the patient (if possible), the Health Care Agent, or the patient's family.

If you are near the end of your life or have an illness that will not improve, you can choose whether you want CPR to be done.

Making the decision:

- **If you do want to receive CPR**, you do not have to do anything.
- **If you do not want CPR**, talk with your doctor about creating a DNR order and include your wishes in your Health Care Proxy/Living Will and make them known to friends/family.
- **If you have a DNR order**, you still have the right to change your mind and request CPR.

Nonhospital Order Not to Resuscitate: Hospitals have their own forms. If you are too sick to agree to a DNR, your health care agent or your closest family member can consent. You can also write DNR instructions on your Health Care Proxy form or Living Will.

NEW YORK STATE DEPARTMENT OF HEALTH

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: _____

Date of Birth: _____

Do not resuscitate the person named above.

*Physician's or Nurse Practitioner's Signature: _____

Print Name: _____

License Number: _____

Date: _____

It is the responsibility of the physician or nurse practitioner to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

For use if you have an incurable illness;
Ask physician to complete.

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.

For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.

DOH-3474 (12/18)

MOLST Form: Physician Medical Orders for Life-Sustaining Treatment

The medical order for life-sustaining treatment (MOLST) can only be completed by your physician.

The MOLST form is a bright pink medical order form that outlines the patient's wishes for life-sustaining treatment. MOLST orders are followed by EMS personnel in the pre-hospital setting. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST instructions regarding end-of-life care.

- **What it does:** It tells health care providers your medical orders for life-sustaining treatment. It is NOT an advance directive but medical orders completed by your physician.
- **When it takes effect:** When signed by your doctor, it is effective immediately.
- **Standard New York State form?** Yes.

*__Note:__ It is a bright pink medical order signed by a licensed physician or nurse practitioner. This is not intended to replace the Health Care Proxy or Living Will. *See the attached sample form.*

For more information regarding MOLST in New York State, please visit health.state.ny.us or speak with your physician.

The MOLST form must be completed by a physician and is used for end-of-life care.

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form based on the patient's current medical condition, values, wishes, and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician or nurse practitioner must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders, and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician or nurse practitioner and consider asking the physician or nurse practitioner to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the doctor (not a nurse practitioner) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check **one:**

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decisions? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

SECTION C Physician or Nurse Practitioner Signature for Sections A and B

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE* PRINT PHYSICIAN OR NURSE PRACTITIONER NAME DATE/TIME

PHYSICIAN OR NURSE PRACTITIONER LICENSE NUMBER PHYSICIAN OR NURSE PRACTITIONER PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

For questions about Advance Care Planning,
please contact HealthCare Partners:

Michele DiCarlo
MDiCarlo@hcpipa.com
(516) 214-8253

Available Monday - Friday, 8:30 a.m. - 5:30 p.m. EST

To reach us after hours (5:30 p.m. – 8:30 a.m.) and on weekends / holidays:

Please call our Patient Assistance Line (PAL):

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