Access CNY

PARTNERS IN PERSON-CENTERED SERVICES

INFORMATION ABOUT HEALTH CARE DECISONS

Health Care Proxy

MOLST

DNR

February/2017

Introduction

This informational booklet describing different options and procedures for making health care decisions was developed because of a request from a family who found it frustrating to navigate all of the requirements at a time when the family should be spending time with their family member faced with a terminal illness. The different options and many requirements and various forms can be confusing. Much of the information and forms in this booklet can be found in the OPWDD regulations under 14 NYCRR part 633, Section 1750-b of the Surrogate Court Procedure Act, (also called the Health Care Decision Act or HCDA, and guidance from the Department of Health, OPWDD, and other websites.

The hope for the development of this booklet is that individuals, family members, legal guardians, doctors, Service Coordinators and staff can review this information and become more familiar with the many requirements for medical decisions under the OPWDD system, before a medical crisis occurs. Some of the required forms have also been included as attachments in this booklet and also can be found on the OPWDD website. The second hope for this booklet is that it will help individuals, families and staff to feel comfortable about beginning a discussion with an individual on what his/her medical wishes are in the event of a serious illness.

Making health decisions during a serious illness or at the end of an individual's life can be a very difficult and emotional thing to do. Our hope in developing this booklet is that agencies, individuals, and families communicate and work together to ensure that all the requirements are met and that the individual's wishes are followed. During a medical crisis and when the decision has been made to say goodbye to the individual, the focus should be on families spending time with their loved one, not on trying to decipher laws and requirements.

These requirements discussed in this booklet are applicable to individuals with a developmental disability, living in an OPWDD certified residential setting (IRA, ICF, Family Care) and those individuals living in the community who receive OPWDD services. This booklet begins with an overview of the various healthcare decision options and then has a specific section for each option that provides more detail regarding requirements and procedures. This booklet also includes additional website resources and forms that may be required.

Please note: The information summarized in this booklet is for informational purposes only and is not a substitute for legal advice. This booklet reflects the understanding of AccessCNY, which is current as of the date this booklet is published. This information should not be construed as official guidance from any state agency.

This booklet is dedicated to Kelly, Richard, Janice, Patricia, Sage, and all of the others who have left us too soon. Your memories will live on in us forever.

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Difference between Living Will, MOLST, Health Care Proxy, Non-hospital DNR

A **Living Will** is a document that is a statement of the individual's medical wishes to be carried out if the individual should become unable to make his/her own decisions. There is no specific form that must be used in NYS for a living will.

A **Non-Hospital DNR** (Do not resuscitate) is a legal document authorized by NYS that an individual can create to direct medical professionals to not perform CPR when the individual's heart stops beating. This document is used after the individual leaves the hospital. This document must be reviewed and signed by the individual's doctor every **90 days.** With the creation of the MOLST form, a DNR can be included on the MOLST and a separate form is no longer needed.

A **Health Care Proxy** is a legal document in NYS that allows the individual to appoint another person to make medical decisions for the individual when he/she loses the ability to make his/her own decisions about medical treatment. The individual must be able to understand what the purpose of this document is and name someone as his/her health care agent. The health care agent must follow the individual's wishes about his/her medical care. The Health Care Proxy can include the individual's directions about DNR and other medical treatments. If the Health Care Proxy does not include specific directions about tube and IV feedings for nutrition and fluids, the health care agent is not able to make these decisions for the person. There is a specific Health Care Proxy form that must be used in NYS. The Health Care Proxy only needs to be done once unless the individual wants to change it. The Health Care Proxy must be signed and witnessed and there are specific requirements regarding who can witness and who can be a health care agent for the individual.

A **MOLST** is a legal document that must be signed by a NYS licensed doctor. The MOLST documents the individual's (or legal guardian or involved family member, if the individual has been determined to lack the ability to make medical decisions for him/herself) directions regarding medical treatment including life-sustaining treatments. and must be followed by all NYS doctors. For people receiving OPWDD services, the MOLST is completed by the individual's doctor when the individual has a serious medical condition or end of life. The doctor completes and signs the MOLST after the OPWDD checklist is completed. The OPWDD checklist must be reviewed and signed by a NYS licensed psychologist or another NYS licensed doctor approved by OPWDD. There are certain conditions that must be met under the 1750-b law and specific notifications that must be made when the MOLST is created. The OPWDD checklist ensures that all of the requirements are met. If an individual's condition worsens or will not improve, an individual, legal guardian, or family member can request that the life-sustaining treatment be withheld or withdrawn. To protect the individual, there are additional documentation and notification requirements that need to be made by the doctor to ensure no one objects to the request. If the individual leaves the hospital, the MOLST can still be in effect.

The individual's doctor must review and sign the MOLST on a regular basis to ensure there are no changes.

Non-Hospital DNR, Health Care Proxy and Living Wills are used to document the individual's future wishes about his/her medical treatment.

The MOLST is used for immediate decisions about the individual's medical treatment due to a current serious medical or serious chronic condition and applies as soon as the order is signed by the physician. Also, the MOLST includes specific and actionable medical orders that transition with the individual across health care settings. For example, health care proxies and living wills typically contain more general instructions and may not be followed by EMS providers in an emergency

Health Care Proxy

Person is a capable adult	→	HCP created and Health Care agent appointed Copy of HCP kept with individual	→	Health care agent follows HCP after person has been determined that he/she has lost capacity to make decisions

Individual Lacks Capacity and does not have a Health Care Proxy

Legal Guardian or Surrogate (family member) requests MOLST	→	Doctor completes MOLST after OPWDD checklist has been completed	→	MOLST sent to MHLS and copy kept with individual	→	MOLST reviewed by doctor on a regular basis to ensure no changes

Guardian or Surrogate of Individual Without Capacity Request to Withhold or Withdraw Life-Sustaining Treatment (This could be at the same time MOLST is developed)

Legal Guardian or Involved family member requests that Life-sustaining treatment be withheld or stopped	→	Doctor completes section on OPWDD checklist and notifies MHLS and agency CEO within 48 hours or ASAP and documents notification or DDSO Director for those living in community	→	If no objections, treatment is withheld or stopped If objection made→request suspended until mediation or court decision

Non-Hospital DNR

Individual has Non-hospital DNR	→	Non-Hospital DNR sent to MHLS and copy kept with individual	→	Document must be reviewed by doctor every 90 days

Health Care Proxy

What is a Health Care Proxy?

A health care proxy is a document that is created by an individual which gives another person the authority to make medical decisions for that individual when he/she becomes unable to make the decisions for him/herself. The person delegated (agent) must follow the individual's (principal) directions which are included in the health care proxy. A sample Health Care Proxy form is included in the attachment section of the booklet.

Who can create a Health Care Proxy?

Any person who is considered a competent adult may create a health care proxy and appoint a health care agent. According to 633.20, every adult (individual 18 or older) shall be presumed competent to appoint a health care agent unless the individual:

(a) has a legal guardian appointed under article 17-A of the Surrogate's Court Procedure Act
(b) has a committee appointed under article 78 of the Mental Hygiene Law
(c) has a prior court determination that he or she is not capable of appointing a health care agent
(d) is presumed competent but does not understand that he or she is delegating the authority to make decisions about their medical care to another person

The determination of an individual's understanding and capacity to appoint a health care agent should be documented in the individual's record. The team (which may include the individual, family members, service coordinator and staff), doctor, or a psychologist can make this determination by asking the individual questions to determine his/her understanding of what a health care proxy is. If an individual has a legal guardian appointed under 17-A Surrogate Court, a health care proxy is **not** required as the legal guardian has been given the authority to make medical decisions which are in the best interest of the individual. In some cases, the legal guardian may choose to create a health care proxy and appoint another person to be the individual's health care agent, but this is not required.

How to create a Health Care Proxy

The health care proxy form must be signed and dated by the individual, in the presence of **two** adult witnesses. Both witnesses must also sign and date the health care proxy form. If the individual is not physically able to sign the health care proxy form, another person may sign and date the form for the individual in the presence of the two witnesses. The witnesses must document that the individual executed the health care proxy willingly. The person appointed as the health care agent **cannot** sign as one of the witnesses.

Witness Requirements in an OPWDD Certified Residential Setting:

(1) at least one witness must be someone who is not affiliated with the residential facility where the individual lives and one witness must be:
   (a) a NYS licensed physician who is presently employed by the DDSO for at least one year, or
   (b) a NYS licensed psychologist who is presently employed by the DDSO for at least one year, or
   (c) the agency's NYS licensed psychologist, who has been working with people with developmental disabilities for at least two years, or
   (d) a NYS licensed physician who has been approved by OPWDD (some hospitals have doctors who have been approved)

Restrictions on who may be the health care agent or alternate agent:

(1) for an individual living in an OPWDD certified residential setting such as an IRA the health care agent **cannot be** any member on the Board, CEO, IRA employee or physician employed with the agency. If any of the individuals listed are related to the individual through blood, marriage or adoption, then they may be appointed as the health care agent
(2) the individual's primary physician may **not** be appointed as the health care agent

*If the individual resides in a Family Care setting, the Family Care provider may be appointed as the health care agent

The health care proxy must include:

(1) the name of the person who the individual has appointed as his/her health care agent
(2) a statement confirming that the individual has given the health care agent the authority to make health care decisions on his/her behalf when he/she becomes unable to make the decisions

The health care proxy may include:

(1) the individual's wishes or instructions about his/her health care decisions. These health care directions may include, but not limited to:
   (a) administration of artificial nutrition and hydration (feeding tube and IV's)
   (b) dialysis
   (c) artificial respiration
   (d) withholding of life support
   (e) withdrawal of life support
   (f) DNR orders
   (g) Surgical procedures

(2) limitations to the decisions that the health care agent can make on the individual's behalf
(3) that the health care proxy may expire upon a specific date or occurrence of a specific condition. If no specific date or condition is listed, then the health care proxy remains in effect until it is revoked. A health care proxy cannot expire once the individual loses capacity and the agent's authority has been initiated
(4) name of the alternate agent if applicable (who will serve in place of the appointed agent when the physician has determined in writing, that the agent is not reasonably available, willing and competent to serve as the agent; or the agent is not expected to become available, willing and competent to make a timely decision regarding the individual's health care needs)

When does the Health Care Agent begin making decisions for the individual?

The health care agent's ability to make health care decisions for the individual begins when it is determined that the individual lacks capacity to make health care decisions, as a result of the individual's medical condition. The individual's attending physician determines that the individual lacks the capacity to make his/her own health care decisions. When making a determination about the individual's capacity, the attending physician must consult with and receive agreement from a professional who is:

(a) a NYS licensed physician presently employed by the DDSO for at least one year, or
(b) a NYS licensed psychologist presently employed by the DDSO for at least one year, or
(c) the agency's psychologist licensed in NYS, who has been working with people with developmental disabilities for at least two years, or
(d) a NYS licensed physician who has been approved by OPWDD (some hospitals have doctors who have been approved)

After the consultation regarding the individual's capacity to make health care decisions, the physician must document this determination in the individual's medical record and the following notifications must be made by the attending physician:

(a) to the individual, orally and in writing, where there is indication that the individual can understand the notification
(b) to the health care agent
(c) to the CEO of the agency (if the individual lives in a OPWDD **certified** residential setting)
(d) to the conservator for, or committee or guardian of the individual (if applicable)

An individual has the right to object to the determination that he/she lacks the capacity to make health care decisions.

If an individual has been determined to lose capacity to make health care decisions but then regains his/her ability to make health care decisions, the health care agent's authority will stop at this time.

An individual has the right to revoke his/her health care proxy and appoint a new health care proxy. A new health care proxy form should be sent to the individual's physician

The health care agent may <u>not</u> make decisions regarding the administration of artificial nutrition and hydration, if the individual has not made his/her wishes known

The individual's doctor should keep a copy of the health care proxy in the medical chart. In OPWDD certified residential settings, a copy of the individual's health care proxy should be kept in the individual's record

Medical Decisions for Individuals Who Lack Capacity

Health Care Decisions Act (HCDA)

Sometimes an individual lacks the ability to understand medical procedures and is unable to give consent for serious medical treatments, and does not have a legal guardian appointed or a valid Health Care Proxy. It should be documented in the individual's record if, after being assessed by the individual's NYS licensed doctor and a NYS licensed psychologist, that it has been determined that he or she lacks the capacity to make medical decisions for him/herself. If the team is unsure whether the individual has the capacity to make his/her own serious medical decisions, the individual should be assessed by a NYS licensed psychologist and NYS licensed physician (See MOLST section for others who can determine capacity).

Who Can Give Consent?

For an individual with a developmental disability who is 18 years or older and receives OPWDD services, including an OPWDD certified residential setting, but lacks capacity to understand the medical treatment, consent must be obtained by one of the surrogates listed below, which are listed in order of priority:

1. a legal guardian with authority to consent to health care
2. an actively involved spouse
3. a parent
4. an actively involved adult child of the individual
5. an actively involved adult sibling
6. an actively involved adult family member (see definition below)
7. the Consumer Advisory Board for Willowbrook Class
8. a surrogate decision-making committee (SDMC) or a court

If the individual with a developmental disability is under 18 years old, consent must be obtained from one of the surrogates listed below, which are listed in order of priority:

1. a legal guardian with authority to consent to health care
2. an actively involved spouse
3. a parent
4. an actively involved adult sibling
5. an actively involved family member (see definition below)
6. a local commissioner of social services with custody over the minor pursuant to Social Services Law or Family Court Act
7. a surrogate decision-making committee (SDMC) or court

If a surrogate is not reasonably available or willing to make a timely decision, and is not expected to become readily available or willing to make a timely decision, the next person on the list, in order listed above, should be contacted.

Actively involved is defined by the OPWDD regulation (14 NYCRR 633.99) as: "Significant and ongoing involvement in a person's life so as to have sufficient knowledge of the person's needs".

Family member is defined by the OPWDD regulation (14 NYCRR 633.99) as: "Any party related to the individual by blood, marriage or legal adoption".

What Medical Decisions Can the Surrogate Make?

A surrogate will generally have the authority to make all health care decisions that the individual person could make if he/she had capacity. This includes providing consent for professional medical treatments (see definition below), as well as making decisions to withhold or withdraw life-sustaining treatment. Whenever possible the surrogate and the individual's physician should involve the individual in the discussion about his/her care. Medical decisions made by the authorized surrogate must always be in the best interest of the individual.

OPWDD regulation (14 NYCRR part 633) defines professional medical treatment that requires consent as: "a medical, dental, surgical or diagnostic intervention or procedure in which a general anesthetic is used or which involves a significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation or having a significant recovery period".

In the event of a medical emergency, consent is not required if: "the medical, dental, health and hospital services are provided to a person of any age when, in the physician's judgment, an emergency exists creating an immediate need for medical attention". In these medical emergencies, the physician may obtain authorization from the CEO of the agency (if the individual resides in an OPWDD certified setting) if the individual's surrogate is not readily available.

Withholding and Withdrawing Life-Sustaining Treatment:

The HCDA also grants the Surrogate the authority to make decisions regarding the withholding and withdrawal of life-sustaining treatments for the individual who is experiencing serious and life threatening medical conditions. Life-sustaining treatment includes but is not limited to: artificial nutrition and hydration, CPR, chemotherapy, DNR (Do not resuscitate) order, and DNI (Do not Intubate) order. Unless the individual has a valid health care proxy, a decision to withhold or withdraw life-sustaining treatment must be made in accordance with specific procedures determined by OPWDD. These procedures are discussed in more detail in the MOLST section below.

*Sometimes a stand-by guardian is appointed during the 17-A Surrogate court procedure and this person's name is listed in the court papers. A stand by-guardian can immediately take the role of the guardian **only** when the guardian dies, gives up the role, or the guardian is incapacitated. The stand-by guardian only has **60 days** after assuming guardianship to petition the court to become the permanent guardian.

Medical Orders for Life-Sustaining Treatment (MOLST)

What is a MOLST?

The MOLST is a form that is completed by the attending physician to document an individual's end of life medical decisions. Many hospitals (especially in the Syracuse area) use the MOLST form. The MOLST allows individuals, legal guardians, involved family members who have been designated as the individual's representative if the individual lacks the ability to make decisions for him/herself, or the Surrogate Decision Making Committee to make decisions regarding life-sustaining treatments for the individual, that are in the best interest of the individual. If an individual, who has been determined to have the capacity to create a health care proxy, has a valid health care proxy and it includes directions about life sustaining treatment, then a MOLST is not required. The MOLST form is used for people with serious health issues or end of life medical conditions. All health care professionals must follow the medical orders, regardless of what setting the individual is in. When an individual receives services under OPWDD, including residing in an OPWDD certified residential setting such as an IRA, ICF or Family Care, there are additional requirements put in place to protect the individual's rights. A MOLST must be completed on a standardized form called the DOH-5003 MOLST form and signed by a licensed physician.

What is Life-Sustaining Treatment?

Life-sustaining treatment is defined as any medical treatment that can sustain life functions and without this treatment the person will most likely die within a relatively short time period. One of the most common examples of life-sustaining treatment is artificial nutrition and hydration through a feeding tube or IV. In June 2010, the law changed and included CPR as a life sustaining treatment; therefore, a DNR (Do not resuscitate) order and a DNI (Do not intubate) order would need to be listed on a MOLST form.

What steps are involved in creating a MOLST?

For a person receiving services from OPWDD including living in an OPWDD certified residential setting (IRA, ICF, FC) there is a process that includes the use of a checklist before the physician can sign off on a MOLST form. The required OPWDD checklist ensures that the procedures under the Health Care Decisions Act (HCDA) are followed for decisions to withhold or withdraw life-sustaining treatment for the individual. The physician must document that the individual has a serious illness and meets the requirements of 1750-b of the Surrogate's Court Procedure which includes:

1. **Capacity Determination**: The physician must confirm to a reasonable degree of medical certainty and document that the individual lacks the capacity to make health care decisions for him/herself. The physician must consult and get agreement with the following health professional:

(a) a NYS licensed physician presently employed by the DDSO for at least one year, or
(b) a NYS licensed psychologist presently employed by the DDSO for at least one year, or
(c) the agency's NYS licensed psychologist, who has been working with people with developmental disabilities for at least two years, or
(d) a NYS licensed physician who has been approved by OPWDD (some hospitals have doctors who have been approved)

2. **Determination of Necessary Medical Criteria**: The physician with the agreement of a second physician must determine to a reasonable degree of medical certainty and document that the individual has one of the following medical conditions:
   (a) a terminal condition; or
   (b) permanent unconsciousness; or
   (c) is a medical condition other than the person's DD (developmental disability) which requires life-sustaining treatment, is irreversible and will continue indefinitely

AND

The life sustaining treatment would cause an extraordinary burden on the individual due to:
(a) the individual's medical condition other than DD; and
(b) the expected outcome of the life sustaining treatment

3. The physician then completes the OPWDD checklist and signs the checklist with a second witness signature.
4. The physician then completes the MOLST form. The physician and a witness sign the MOLST form.
5. The physician must attach the completed and signed OPWDD checklist to the MOLST and send a copy to MHLS (Mental Hygiene Legal Services).
6. MHLS's primary role is to ensure that the rights of the individual are protected, that the decision is in the best interest of the person and that all required documentation has been completed. MHLS will meet with the individual or may also speak with the legal guardian, family member, doctor or agency provider about the individual's medical condition.
7. If the individual is hospitalized when the MOLST was created and then is released home, the MOLST needs to be reviewed by the individual's doctor on a regular basis to ensure the individual still meets the 1750-b requirements (see above). Although there is no specific frequency written, it is recommended that the individual's doctor reviews the MOLST and signs off that is still applicable every 6 months but minimally every year.
8. For individuals residing in an OPWDD certified setting, a copy of the MOLST and the OPWDD checklist should be kept in the individual's record.

Withholding or Withdrawing Life-Sustaining Treatment

The legal guardian or the individual's authorized representative has the authority to request that additional or current medical life-sustaining treatments be withheld or withdrawn. This is a difficult decision for the guardian and family to make. There are certain criteria under 1750-b and additional notifications that must be made to protect the individual under the law, especially when the individual has a developmental disability and receives services under OPWDD

1. If the legal guardian or authorized family member has requested that artificial nutrition or hydration be withdrawn or withheld, the physician must determine and document on the OPWDD checklist form that:
   (a) there is no reasonable hope of maintaining life; or
   (b) the artificially provided nutrition or hydration poses an extraordinary burden

2. At least 48 hours prior to the withdrawal or withholding of **any** life-sustaining treatment (including requesting a DNR), or as soon as possible, the attending physician must notify:
   (a) the individual with DD, unless therapeutic exception applies; and
   (b) MHLS and the CEO (Executive Director) of the agency if the person lives in an OPWDD certified residential setting (IRA, ICF, FC); or
   (c) the Director of the Developmental Disabilities Regional Office (DDRO) (473-5050) if the individual does not live in a certified residential setting but receives OPWDD services

The above parties being notified have the right to object to the decision to withhold or withdraw life-sustaining treatment from the individual. The attending physician will document the notifications on the OPWDD checklist form. If someone objects to the request to withdraw or withhold life-sustaining treatment; the request to withhold or withdraw life-sustaining treatment will be suspended until further mediation or court proceedings determine whether the request will be approved. The attending physician may request the hospital's Ethics Committee review the request if the physician is not in agreement with the request by the legal guardian or authorized family member to withdraw or withhold life-sustaining treatment from the individual.

<u>Non-Hospital DNR</u>

Before the MOLST form was created, an individual, legal guardian or designated surrogate could create a DNR and a non-hospital DNR. A non-hospital DNR is created when the individual leaves the hospital and wants it documented that he/she has a DNR order.

A non-hospital DNR is:

1. Created by a physician of a developmental center to be used after the individual leaves the developmental center
2. Created by a physician in a hospital to be used upon release of the individual from the hospital
3. Created by the individual's physician

Determination must be made as to whether the individual has the capacity to understand the DNR order and gives consent. If the individual lacks the capacity, the designated surrogate may create the non-hospital DNR on behalf of the individual. (refer to MOLST procedure above for process for determining capacity or surrogate's ability to make decision)

The individual has the right to revoke the non-hospital DNR at any time. The individual's doctor must review the non-hospital DNR every **<u>90 days</u>** and document this review on the form

In an OPWDD certified residential setting (IRA, ICF, FC) a copy of the non-hospital DNR should be kept in the individual's record.

Additional Resources

www.opwdd.ny.gov

www.dos.ny/info/nycrr

www.health.ny.gov

www.nysba.org

www.nycourts.gov **(Mental Hygiene Legal Services—MHLS)**

www.compassionandsupport.org **(information and forms)**

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.

(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.

Date ______________________

Name of Witness 1
(print) ______________________

Signature ______________________

Address ______________________

____

Date ______________________

Name of Witness 2
(print) ______________________

Signature ______________________

Address ______________________

____

NEW YORK STATE | Department of Health

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.

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN 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 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 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 and consider asking the physician 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 a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

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.

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 decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN 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

HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.

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

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT ______ DATE OF BIRTH (MM/DD/YYYY) ______

SECTION E — Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

- ☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- ☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- ☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

- ☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should ***not*** be checked if full CPR is checked in Section A.)
- ☐ **A trial period** *Check one or both:*
  - ☐ **Intubation and mechanical ventilation**
  - ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**
- ☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

- ☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- ☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. *Check one each for feeding tube and IV fluids:*

- ☐ **No feeding tube**
- ☐ **A trial period of feeding tube**
- ☐ **Long-term feeding tube, if needed**
- ☐ **No IV fluids**
- ☐ **A trial period of IV fluids**

Antibiotics *Check one:*

- ☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- ☐ **Determine use or limitation of antibiotics when infection occurs.**
- ☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, etc.).

______

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

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 decision? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

Physician Signature for Section E

PHYSICIAN SIGNATURE ______ PRINT PHYSICIAN NAME ______ DATE/TIME ______

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LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on This MOLST Form

The physician must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on This MOLST Form *Continued from Page 3*

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
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MOLST LEGAL REQUIREMENTS CHECKLIST FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

______________________ ______________________

LAST NAME/FIRST NAME DATE OF BIRTH

____

ADDRESS

Note: Actual orders should be placed on the MOLST form with this completed checklist attached. Use of this checklist is required for individuals with developmental disabilities (DD) who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life sustaining treatment (LST) for individuals with DD who lack capacity and do not have a health care proxy must comply with the process set forth in the Health Care Decisions Act for persons with MR (HCDA) [SCPA § 1750-b (4)]. Effective June 1, 2010, this includes the issuance of DNR orders.

Step 1 – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

____ a. 17-A guardian ____________________________
____ b. actively involved spouse ____________________________
____ c. actively involved parent ____________________________
____ d. actively involved adult child ____________________________
____ e. actively involved adult sibling ____________________________
____ f. actively involved family member ____________________________
____ g. Willowbrook CAB (full representation)
____ h. Surrogate Decision Making Committee (MHL Article 80)

Step 2 – 1750-b surrogate has a conversation or a series of conversations with the treating physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withhold or withdraw LST, either orally or in writing.

Specify the LST that is requested to be withdrawn or withheld: ____________________________

____

____

____ **Decision made orally**

______________________ ______________________

Witness – Attending Physician **Second Witness**

____ **Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician).**

LAST NAME/FIRST NAME ____________ DATE OF BIRTH ____________

Step 3 – Confirm individual's lack of capacity to make health care decisions. Either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a DDSO; or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.

____________ ____________

Attending Physician Concurring Physician or Licensed Psychologist

Step 4– Determination of Necessary Medical Criteria.

We have determined to a reasonable degree of medical certainty that **both** of the following conditions are met:

(1) the individual has one of the following medical conditions:

_____ a. a terminal condition; (briefly describe ____

____); or

_____ b. permanent unconsciousness; or

_____ c. a medical condition other than DD which requires LST, is irreversible and which will continue indefinitely (briefly describe ____

____)

AND

(2) the LST would impose an extraordinary burden on the individual in light of:

_____ a. the person's medical condition other than DD (briefly explain ______________________

____) and

_____ b. the expected outcome of the LST, notwithstanding the person's DD (briefly explain __________

____)

If the 1750-b surrogate has requested that artificially provided nutrition or hydration be withdrawn or withheld, one of the following additional factors must also be met:

_____ a. there is no reasonable hope of maintaining life (explain ______________________________

____); or

_____ b. the artificially provided nutrition or hydration poses an extraordinary burden (explain__________

____

____).

____________ ____________

Attending Physician Concurring Physician

LAST NAME/FIRST NAME DATE OF BIRTH

Step 5 – Notifications. At least 48 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time prior to a decision to withhold LST, the attending physician must notify the following parties:

_____ the person with DD, unless therapeutic exception applies
notified on ___/___/___

_____ if the person is in or was transferred from an OPWDD residential facility

_____ Facility Director notified on ___/___/___

_____ MHLS notified on ___/___/___

_____ if the person is not in and was not transferred from an OPWDD residential facility

_____ the director of the local DDSO notified on ___/___/___

Step 6 - I certify that the 1750-b process has been complied with, the appropriate parties have been notified and no objection to the surrogate's decision remains unresolved.

Attending Physician Date

Note: The MOLST form may ONLY be completed with the 1750-b surrogate after all 6 steps on this checklist have been completed.

State of New York
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 Signature ________________

Print Name ________________________

License Number _________________

Date __ / __ / __

It is the responsibility of the physician 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.

DOH-3474 (04/09)

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 de*cisions 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.

(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.

Date ____________________ Date ____________________

Name of Witness 1 *(print)* ____________________ Name of Witness 2 *(print)* ____________________

Signature ____________________ Signature ____________________

Address ____________________ Address ____________________

____________________ ____________________

NEW YORK STATE | Department of Health

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 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 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 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 and consider asking the physician 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 a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

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.

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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.

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

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

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PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

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Check all advance directives known to have been completed:

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

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Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

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- ☐ **A trial period** *Check one or both:*
  - ☐ **Intubation and mechanical ventilation**
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- ☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

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- ☐ **A trial period of feeding tube**
- ☐ **Long-term feeding tube, if needed**
- ☐ **No IV fluids**
- ☐ **A trial period of IV fluids**

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Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

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 decision? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

Physician Signature for Section E

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

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on This MOLST Form

Continued from Page 3

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
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MOLST LEGAL REQUIREMENTS CHECKLIST FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

______________________________ ______________________

LAST NAME/FIRST NAME DATE OF BIRTH

____

ADDRESS

Note: Actual orders should be placed on the MOLST form with this completed checklist attached. Use of this checklist is required for individuals with developmental disabilities (DD) who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life sustaining treatment (LST) for individuals with DD who lack capacity and do not have a health care proxy must comply with the process set forth in the Health Care Decisions Act for persons with MR (HCDA) [SCPA § 1750-b (4)]. Effective June 1, 2010, this includes the issuance of DNR orders.

Step 1 – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

_____ a. 17-A guardian ____

_____ b. actively involved spouse ______________________________________

_____ c. actively involved parent ______________________________________

_____ d. actively involved adult child ___________________________________

_____ e. actively involved adult sibling __________________________________

_____ f. actively involved family member _________________________________

_____ g. Willowbrook CAB (full representation)

_____ h. Surrogate Decision Making Committee (MHL Article 80)

Step 2 – 1750-b surrogate has a conversation or a series of conversations with the treating physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withhold or withdraw LST, either orally or in writing.

Specify the LST that is requested to be withdrawn or withheld: ________________________________

____

____

_____ Decision made orally

____________________________ ____________________________________

Witness – Attending Physician Second Witness

_____ Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician).

______________________________ ___________________________
LAST NAME/FIRST NAME DATE OF BIRTH

Step 3 – Confirm individual's lack of capacity to make health care decisions. Either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a DDSO; or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.

____________________________________ ____
Attending Physician Concurring Physician or Licensed Psychologist

Step 4– Determination of Necessary Medical Criteria.

We have determined to a reasonable degree of medical certainty that **both** of the following conditions are met:

(1) the individual has one of the following medical conditions:

_____ a. a terminal condition; (briefly describe ____

____); or
_____ b. permanent unconsciousness; or
_____ c. a medical condition other than DD which requires LST, is irreversible and which will continue indefinitely (briefly describe____

____)

AND

(2) the LST would impose an extraordinary burden on the individual in light of:

_____ a. the person's medical condition other than DD (briefly explain_______________________________

____) and

_____ b. the expected outcome of the LST, notwithstanding the person's DD (briefly explain ____________

____)

If the 1750-b surrogate has requested that artificially provided nutrition or hydration be withdrawn or withheld, one of the following additional factors must also be met:

_____ a. there is no reasonable hope of maintaining life (explain__________________________________

____); or

_____ b. the artificially provided nutrition or hydration poses an extraordinary burden (explain__________

____

____).

__________________________ ____________________________________
Attending Physician Concurring Physician

_________________________________ _____________________________
LAST NAME/FIRST NAME DATE OF BIRTH

Step 5 – Notifications. At least 48 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time prior to a decision to withhold LST, the attending physician must notify the following parties:

_____ the person with DD, unless therapeutic exception applies
notified on ___/___/___

_____ if the person is in or was transferred from an OPWDD residential facility

______ Facility Director notified on ____/___/____

______ MHLS notified on ____/___/____

_____ if the person is not in and was not transferred from an OPWDD residential facility

______ the director of the local DDSO notified on ____/___/____

Step 6 - I certify that the 1750-b process has been complied with, the appropriate parties have been notified and no objection to the surrogate's decision remains unresolved.

____ ____
Attending Physician Date

Note: The MOLST form may ONLY be completed with the 1750-b surrogate after all 6 steps on this checklist have been completed.

State of New York
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 Signature________________

Print Name _________________________

License Number _________________

Date __ / __ / __

It is the responsibility of the physician 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.

DOH-3474 (04/09)