3455132

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT

(MOLST) www.molst-ma.org

Patient's Name Paul Nordberg

Date of Birth 10/3/1938

Medical Record Number if applicable: 3455132

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

- → This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
- → Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- → If any section is not completed, there is no limitation on the treatment indicated in that section.
- → The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A — Mark one circle →

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

● Do Not Resuscitate ○ Attempt Resuscitation

B — Mark one circle →

VENTILATION: for a patient in respiratory distress

● Do Not Intubate and Ventilate ○ Intubate and Ventilate

Mark one circle → ● Do Not Use Non-invasive Ventilation (e.g. CPAP) ○ Use Non-invasive Ventilation (e.g. CPAP)

C — Mark one circle →

TRANSFER TO HOSPITAL

○ Do Not Transfer to Hospital (*unless needed for comfort*) ● Transfer to Hospital

PATIENT or patient's representative signature

D — ***Required***

Mark one circle and fill in every line for valid Page 1.

Mark one circle below to indicate who is signing Section D:

● **Patient** ○ **Health Care Agent** ○ **Guardian*** ○ **Parent/Guardian* of minor**

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

X Paul Nordberg
Signature of Patient (or Person Representing the Patient)

9/26/2016
Date of Signature

PAUL NORDBERG
Legible Printed Name of Signer

978 356 0993
Telephone Number of Signer

CLINICIAN signature

E — ***Required***

Fill in every line for valid Page 1.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

X Joseph Benjamin Gocker
Signature of Physician, Nurse Practitioner, or Physician Assistant

7/26/2016 09:39AM
Date and Time of Signature

Joseph Benjamin Gocker
Legible Printed Name of Signer

617-724-1100
Telephone Number of Signer

Optional Expiration date (if any) and other information

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____

Health Care Agent Printed Name _____ Telephone Number _____

Primary Care Provider Printed Name _____ Telephone Number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Patient's Name: PAUL NORDBERG Patient's DOB 10/3/1914 Medical Record # if applicable 345-51-32

F — **Statement of Patient Preferences for Other Medically-Indicated Treatments**

INTUBATION AND VENTILATION			
Mark one circle →	● Refer to Section B on Page 1	○ Use intubation and ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss
NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
Mark one circle →	● Refer to Section B on Page 1	○ Use non-invasive ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss
DIALYSIS			
Mark one circle →	● No dialysis	○ Use dialysis ○ Use dialysis, but short term only	○ Undecided ○ Did not discuss
ARTIFICIAL NUTRITION			
Mark one circle →	● No artificial nutrition	○ Use artificial nutrition ○ Use artificial nutrition, but short term only	○ Undecided ○ Did not discuss
ARTIFICIAL HYDRATION			
Mark one circle →	● No artificial hydration	○ Use artificial hydration ○ Use artificial hydration, but short term only	○ Undecided ○ Did not discuss

Other treatment preferences specific to the patient's medical condition and care

SEE SCANNED MEDICAL DIRECTIVE

PATIENT or patient's representative signature

G

Required

Mark one circle and fill in every line for valid Page 2.

Mark one circle below to indicate who is signing Section G:

● **Patient** ○ **Health Care Agent** ○ **Guardian*** ○ **Parent/Guardian* of minor**

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

X Paul Nordberg — Signature of Patient (or Person Representing the Patient)

2/20/2016 — Date of Signature

PAUL NORDBERG — Legible Printed Name of Signer

978-356-0993 — Telephone Number of Signer

CLINICIAN signature

H

Required

Fill in every line for valid Page 2.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.

X Joseph Benjamin Crocker — Signature of Physician, Nurse Practitioner, or Physician Assistant

7/26/16 09:39 — Date and Time of Signature

Joseph Benjamin Crocker — Legible Printed Name of Signer

617-724-9100 — Telephone Number of Signer

Additional Instructions For Health Care Professionals

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.

→ Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*

→ Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

Advanced Directive

In the event that I am incapacitated and unable to speak for myself, I am outlining my wishes and goals for care. My wishes are simple: independent functioning. I will appreciate the help and best judgment of those taking care of me as to what specifics would support my wishes and goals, with the recognition that I cannot be young and healthy forever any more than alive forever.

Health Care Agent

I am the last of a family branch. I have no surviving close kin who know or can speak my wishes for me. As a deliberate decision, I have not designated a health care agent, formally or informally. Rather than leaving open to speculation what I *would* wish or who could speak for me, I am making my best efforts here to describe what I *do* wish.

Goals for care

My fundamental wish is to be able to function well independently. I do not wish my life to be prolonged if I lose this ability. At a bare minimum, independent functioning includes the abilities to walk, talk, see, and reason. I do not fear death. What I do dread, above all things, is dementia. "Life" for me needs to include the mental capacity to perform the ordinary tasks of daily life.

If I am in an incapacitated state that appears to those taking care of me most likely to be long-term, I ask that they avoid any and all measures, chronic or acute, to prolong life without realistic prospect of recovery of the functional abilities I have described. If my incapacity appears to have reasonable prospects of being reversible, they may consider specific short-term measures to promote my recovery of health and good functional status. Some examples are listed below, but the list is not absolute or exhaustive. The goal is more important to me than the means.

Examples of specific therapies and measures

As far as I am able to imagine, in no circumstances would I would ever want –

- Attempted resuscitation (compressions or shock) following cardiac arrest;
- Extended ventilation, chronic need for other respiratory assistance, or tracheotomy;
- Feeding tube, colostomy, or other stoma;
- Amputation of a limb or part of a limb;
- A prolonged, non-progressing acute care episode with multiple workups and treatments that are not advancing my stated goals;
- Long-term nursing care (even on the grounds of my own safety, or that I am unable to care for myself);
- Other long-term institutional care, including in particular dementia care (unless I am formally judged by a court of law to pose a danger to others); or
- Experimental therapies to which I have not fully consented prior to becoming incapacitated.

As part of a treatment plan for a potentially reversible condition, I might elect short-term intubation during a procedure in which this is routinely done, for example surgery to repair a broken hip. If I am in generally good health with a meaningful pulse but an isolated arrhythmia appearing amenable to shock, I might elect focused, bounded attempts at cardioversion.

When the success of potential treatments is uncertain, I would ask for fewer rather than more.

My then attending physician may make the determination that I appear to be incapacitated. If the incapacity is due to dementia or ongoing poor cognitive status, I ask that he or she consult with a second physician experienced in geriatric or dementia care before overruling or disregarding the preferences explicitly stated above.

I have worked very carefully and deliberately over the past year to identify and articulate these wishes, which reflect extensive professional and personal experience with end of life care, and which I have recorded here and am signing this May 20, 2013.

Paul Nordberg
19 Pleasant Street
Ipswich, Massachusetts

* * *

I have reviewed and reaffirm the statement above on this July 22, 2016. My end of life wishes reflect my MGH professional experience in the reviews of some five thousand deaths, and my personal experience over two decades with the dementia, illnesses and deaths of both of my parents.

witnessed: 7/26/16

Massachusetts Medical Orders for Life-Sustaining Treatment

IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

— Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.

— Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.

— Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.

— Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

— Access the *Clinician Checklist for Using MOLST with Patients* at: http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients.

— Listen to *MOLST Overview for Health Professionals* at: http://www.molst-ma.org/molst-training-line.

— Access the MOLST website at: http://www.molst-ma.org periodically for MOLST form updates.

— For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit http://www.molst-ma.org.

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* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at http://www.staples.com, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at http://www.officedepot.com.