

Aug. 1. 2016 11:30AM

No. 5084 P. 9

3455132

**MASSACHUSETTS MEDICAL ORDERS
for LIFE-SUSTAINING TREATMENT**


(MOLST) www.molst-ma.org

Patient's Name Paul NorbergDate of Birth 10/3/1948Medical 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 <input checked="" type="radio"/> Do Not Resuscitate <input type="radio"/> Attempt Resuscitation	
B Mark one circle →	VENTILATION: for a patient in respiratory distress <input checked="" type="radio"/> Do Not Intubate and Ventilate <input type="radio"/> Intubate and Ventilate	
Mark one circle →	<input checked="" type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP) <input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)	
C Mark one circle →	TRANSFER TO HOSPITAL <input type="radio"/> Do Not Transfer to Hospital (unless needed for comfort) <input checked="" type="radio"/> 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: <input checked="" type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> 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. <u>Paul Norberg</u> Signature of Patient (or Person Representing the Patient) <u>7/26/2016</u> Legible Printed Name of Signer Date of Signature <u>Paul Norberg</u> Legible Printed Name of Signer <u>970 356 0993</u> Legible Printed Name of Signer 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. <u>Joseph Benjamin Gocher</u> Signature of Physician, Nurse Practitioner, or Physician Assistant <u>7/26/2016 09:39AM</u> Legible Printed Name of Signer Date and Time of Signature <u>Joseph Benjamin Gocher</u> Legible Printed Name of Signer <u>617-724-1100</u> Legible Printed Name of Signer 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.

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Patient's Name: PAUL NORDBERG Patient's DOB 10/3/1919 Medical Record # if applicable 345-51-32

F	Statement of Patient Preferences for Other Medically-Indicated Treatments		
	INTUBATION AND VENTILATION		
Mark one circle →	<input checked="" type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use intubation and ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Mark one circle →	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)		
	<input checked="" type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use non-invasive ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Mark one circle →	DIALYSIS		
	<input checked="" type="radio"/> No dialysis	<input type="radio"/> Use dialysis <input type="radio"/> Use dialysis, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Mark one circle →	ARTIFICIAL NUTRITION		
	<input checked="" type="radio"/> No artificial nutrition	<input type="radio"/> Use artificial nutrition <input type="radio"/> Use artificial nutrition, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Mark one circle →	ARTIFICIAL HYDRATION		
	<input checked="" type="radio"/> No artificial hydration	<input type="radio"/> Use artificial hydration <input type="radio"/> Use artificial hydration, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
Other treatment preferences specific to the patient's medical condition and care _____			
<u>SEE SCANNED MEDICAL DIRECTIVE</u>			

PATIENT or patient's representative signature G Required	Mark one circle below to indicate who is signing Section G:	
	<input checked="" type="radio"/> Patient	<input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor
Mark one circle and fill in every line for valid Page 2.	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.	
	Signature of Patient (or Person Representing the Patient) <u>PAUL NORDBERG</u>	Date of Signature <u>7/20/2016</u> Telephone Number of Signer <u>978-356-0993</u>
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.	
	Signature of Physician, Nurse Practitioner, or Physician Assistant <u>Joseph Benjamin Crader</u>	Date and Time of Signature <u>7/26/16 09:39</u> Telephone Number of Signer <u>617-724-0100</u>

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.

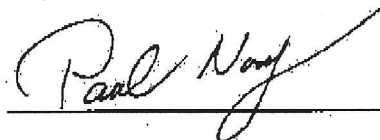
As part of a treatment plan for a potentially reversible condition, I might elect short-term intubation during a procedure in which this is routinely done, for example surgery to repair a broken hip. If I am in generally good health with a meaningful pulse but an isolated arrhythmia appearing amenable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

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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.

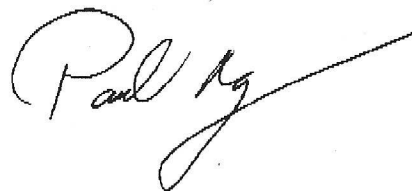
I have worked very carefully and deliberately over the past year to identify and articulate these wishes, which reflect extensive professional and personal experience with end of life care, and which I have recorded here and am signing this May 20, 2013.

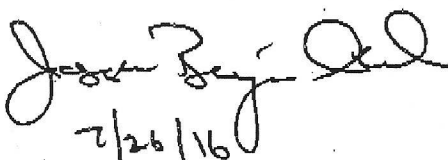


Paul Nordberg
19 Pleasant Street
Ipswich, Massachusetts

* * *

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

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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>.

* 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>.