

## ***Who's Your Agent?<sup>®</sup> Program***

[Getting Started Tool Kit](#)[Next Steps Tool Kit](#)

### **Next Steps Tool Kit**

Getting the best possible care that honors your choices is a lifelong journey. You can make a personal health care plan and direct your care at every phase of health: when Promoting Everyday Wellness, Managing Health and Chronic Illness, and Living with Serious Advancing Illness.

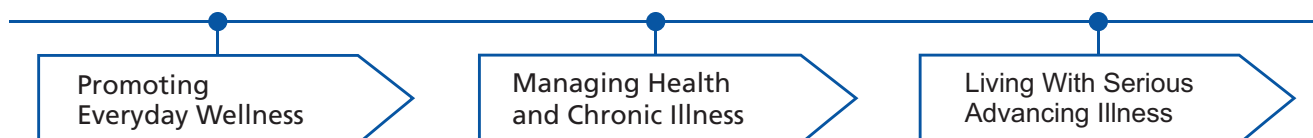


This step-by-step kit builds on your planning discussions and adds/updates planning documents all through your lifetime. You'll find information, tools, and discussions guides to build your plan and put your plan into action. For more information, visit [www.honoringchoicesmass.com](http://www.honoringchoicesmass.com)

**Every competent adult, 18 years old & older, can make a health care plan.**

**Here's information & tools to direct your care at every phase of health.**

Now that you have started to make your personal plan with a Health Care Proxy and Personal Directive in the Getting Started Tool Kit, you can build on your planning discussions and add documents to your plan. The Next Steps Tool Kit helps you to talk with your Health Care Agent, family and care providers to get the care you want all through your life. Use the checklist below to build your plan and put it into action!



### **Promoting Everyday Wellness.** Stay healthy and receive proactive, preventative care.

- ☐ **Talk to your Health Care Agent (Agent) & Family:** What's important to you? Share your values and choices.
- ☐ **Talk with your Doctors & Care Providers:** Use *5 Things to Talk About with Your Care Providers* handy discussion guide to start a planning discussion.
- ☐ **Update & Add to Your Plan:** Write down your choices in the 5 Massachusetts planning documents — What's in My Plan?: I have a ☐ Health Care Proxy ☐ Personal Directive (see "Getting Started Tool Kit").

### **Managing Health & Chronic Illness.** Improve wellness as you age and receive goal-centered care.

- ☐ **Talk to your Agent & Family:** Discuss your changing health needs and care choices.
- ☐ **Talk with your Doctors & Care Providers:** Use *5 Things to Talk About with Your Care Providers: Chronic Illness Discussion Guide*.
- ☐ **Update & Add to Your Plan:** Review *Things to Know About a Durable Power of Attorney*. Choose a trusted person to be your financial decision-maker to manage your money, property & business affairs.
- ☐ **What's in My Plan:** I have a ☐ Health Care Proxy ☐ Personal Directive ☐ Durable Power of Attorney

### **Living with Serious, Advancing Illness.** Enhance quality of life and honor care choices.

- ☐ **Talk to your Agent & Family:** Explore your priorities and consider tradeoffs to get to your care goals.
- ☐ **Talk with your Doctors & Care Providers:** Use *5 Things to Talk About with Your Care Providers: Serious Advancing Illness Discussion Guide*.
- ☐ **Update & Add to Your Plan:** Review *Things to Know about MOLST and CC/DNR*. Consider talking with your clinician about your current condition and the benefits, risks and possible outcomes of attempting CPR & life-sustaining treatments. You & your clinician can write down your choices in a Medical Orders for Life-Sustaining Treatment form (MOLST) and a Comfort Care / Do No Resuscitate Order (CC/DNR).
- ☐ **Review *Things to Know About Palliative Care*:** Manage the pain, symptoms & stress of serious illness.
- ☐ **Review *Things to Know About Hospice Care*:** Learn about the care and comfort available at the end of life.

#### **What's in My Plan:**

I have a ☐ Health Care Proxy ☐ Personal Directive ☐ Durable Power of Attorney ☐ MOLST ☐ CC/DNR

## Talk to Your Doctors and Care Providers Discussion Guide

## 5 Things To Talk About With Your Care Providers

*To make a plan for the best possible care.*

## INFORMATION TO MAKE CHOICES

**1. I'd like to understand more about my health or illness and treatment options:**

- Here's what I know about my health or illness. Here's what I'd like to know today.
- What's ahead for me? What information would help me to plan for the future?

## MY GOALS

**2. I want to discuss my goals and explore the care I want and do not want:**

- Given my personal values, beliefs and priorities, here's what is important to me.
- Here's what worries or concerns me.

## MY PLAN

### 3. Let's discuss my care plan and writing down my choices in planning documents:

- What's the plan for getting me to my goals?; What are the next steps?
- I want to choose a Health Care Agent; can you help me with a Health Care Proxy?
- Here's a copy of my Health Care Proxy; can you place it in my medical record?

## KNOW MY CHOICES

**4. I'd like to make sure you know my choices and that my medical record is up-to-date:**

- Let's review my current health or illness, and changes in my priorities and choices.
- I'd like to revise/add a planning document and review the documents in my record.

## HONOR MY CHOICES

**5. I'd like to make sure my care providers honor my choices all through my life:**

- In an emergency, or if I can't speak with you, how will my choices be followed?
- I'd like to bring in my family / Agent to talk about my plan and honoring my choices.

**5 Things to Talk About with Your Care Providers** is a basic discussion guide to help you start a planning discussion to promote lifelong wellness and receive person-centered care. Start with one or more questions that make sense to you, and write down your own questions below to bring to your next appointment.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

## Managing Health & Chronic Illness Care Discussion Guide

### 5 Things To Talk About With Your Care Providers

*To make a plan for the best possible care.*

|                                    |  |
|------------------------------------|--|
| <b>INFORMATION TO MAKE CHOICES</b> | <b>1. I'd like to understand more about my health or illness and treatment options:</b> <ul style="list-style-type: none"> <li>• Here's my understanding of my illness today. What am I missing?</li> <li>• What's ahead? What's the likely path of my illness, possible complications &amp; treatment options?</li> <li>• I can manage my symptoms and pain most days. What are my options to have better days?</li> </ul>  |
| <b>MY GOALS</b>                    | <b>2. I want to discuss my goals and explore the care I want and do not want:</b> <ul style="list-style-type: none"> <li>• Let's talk about my condition, care goals &amp; priorities. Here's how things have changed for me.</li> <li>• Here's what is most important to me given my values, family, religious and cultural beliefs.</li> <li>• Here's what frustrates and upsets me; here's what worries me about the future.</li> <li>• I'd like to prolong my good health and 'quality of life' as long as possible? How do we do that?</li> </ul> |
| <b>MY PLAN</b>                     | <b>3. Let's discuss my care plan and writing down my choices in planning documents:</b> <ul style="list-style-type: none"> <li>• Let's review the plan to get me to my goals. What are your recommendations for next steps?</li> <li>• I'd like to complete a Health Care Proxy and put it in my medical record. Can you help?</li> <li>• Can you help me talk with my family/Agent about our plan and what's ahead for me?</li> </ul>   |
| <b>KNOW MY CHOICES</b>             | <b>4. I'd like to make sure you know my choices and that my medical record is up-to-date:</b> <ul style="list-style-type: none"> <li>• At this point in my health, here is the medical care I want and do not want.</li> <li>• Let's review my medical record to make sure the documents and notes are up-to-date.</li> <li>• If I become ill and can not speak to you, how will other doctors access my medical record?</li> </ul>  |
| <b>HONOR MY CHOICES</b>            | <b>5. I'd like to make sure my care providers honor my choices all through my life:</b> <ul style="list-style-type: none"> <li>• In an emergency, what steps can we take to ensure all my doctors will know &amp; honor my choices?</li> <li>• Can we meet with my family/Agent to talk about everyone's role in honoring my choices?</li> </ul>   |

**Managing Health & Chronic Illness Care Discussion Guide** offers some additional questions that go with the basic discussion guide. Start with one or more questions that make sense to you, and write down your own questions below to bring to your next appointment.

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## Things to Know About a Durable Power of Attorney

### 1. What is a Durable Power of Attorney?

- A durable power of attorney is a legal document in which you appoint a trusted person to manage and protect your financial matters — your money, property and business affairs — if you are not able to manage your financial matters yourself
- The trusted person you appoint is called an 'Attorney-in-fact', who follows your instructions and makes financial decisions on your behalf to manage and safeguard your financial matters

### 2. Who can sign a Durable Power of Attorney?

Every competent adult has the choice to sign a Durable Power of Attorney. An adult must be:

- 18 years old and older; able to understand that he or she is giving another person the legal authority to manage his or her financial affairs if the adult becomes disabled or incapacitated; and under no constraint or undue influence to sign the legal document

### 3. Who can be my Attorney-in-Fact?

- Any adult you trust - a spouse, family member, a friend, or a professional or business entity, preferably someone who has the ability to be financially responsible

### 4. How does a Durable Power of Attorney work?

- You have the right to manage your money, property, and business as you like
- This document tells your Attorney-in-fact when to step in to help you (either immediately or if you become disabled or incapacitated), and lists the exact decision making powers you give your Attorney-in-fact to act on your behalf
- "Durable" means your Attorney-in-fact can act even if you become incapacitated

### 5. What decision making authority can I give my Attorney-in-Fact?

- You can give your Attorney-in-fact limited powers with authority to perform tasks like paying the bills, signing checks, buying or selling property, or managing your business, or
- You can give your Attorney-in-fact general powers with authority to manage all financial affairs
- You tell your Attorney-in-fact what's important to you in taking specific actions and making financial or business decisions

### 6. Can I change my mind or cancel or revoke a Durable Power of Attorney?

- You can appoint a new Attorney-in-fact, change the decision making authority, cancel or revoke the document as long as you are competent

### 7. How do I complete a Durable Power of Attorney?

- Although it is not required in Massachusetts, it is generally recommended that you ask an attorney to draft a Durable Power of Attorney for you. An attorney can tailor the document to your situation and include specific powers to help ensure your Attorney-in-fact can provide for your long term care and safeguard your estate all through your lifetime.

## Serious Advancing Illness Care Discussion Guide

### 5 Things To Talk About With Your Care Providers

*To make a plan for the best possible care.*

#### INFORMATION TO MAKE CHOICES

#### 1. I'd like to understand more about my health or illness and treatment options:

- Here's my understanding of my illness today and how it's changing. What am I missing?
- What's ahead for me? What are the possible treatment options and choices I will likely face?
- My symptoms, pain and stress of living with my illness are getting harder to manage. Would Palliative Care or other treatment options be helpful?
- I'd like to consider my options and talk with my family. What's our timeline for making decisions?

#### MY GOALS

#### 2. I want to discuss my goals and explore the care I want and do not want:

- Let's talk about my condition, care goals & priorities. Here's how things have changed for me.
- Here's what is most important to me given my values, family, religious and cultural beliefs.
- Here's what frustrates or scares me; other than my health, here's what concerns me most.
- I'd like to have more good days than bad days. Here's what I am able to do on a good day.
- If I want to limit or stop active treatments and be kept comfortable, what would that mean for me?

#### MY PLAN

#### 3. Let's discuss my care plan and writing down my choices in planning documents:

- Here is the medical care I want and do not want. What are your recommendations for next steps?
- I have a Health Care Agent who knows my care choices; OR, I do not have an Agent-can you help?
- I'd like to talk about my choices regarding CPR and life sustaining treatments. Can you tell me about the benefits, risks, and likely outcomes given my current condition? I'd like to make choices and write down my choices with you in a MOLST form.
- As my illness progresses, what treatment decisions and possible tradeoffs will I need to consider?
- At what point may it make sense to consider hospice care? What support & treatment does it offer?
- Can we meet together with my family/Agent to review the plan and possible outcomes?

#### KNOW MY CHOICES

#### 4. I'd like to make sure you know my choices and that my medical record is up-to-date:

- I'd like to review my medical record and your notes to ensure my choices are clear and up-to-date.
- Is my updated Health Care Proxy in my medical record? If not, here's a copy to place in my record.
- I'd like to update/revise my Health Care Proxy, Personal Directive or MOLST form. Can you help?

#### HONOR MY CHOICES

#### 5. I'd like to make sure my care providers honor my choices all through my life:

- In an emergency situation, will all the people caring for me be able to honor my choices?
- Can you help me make sure all my care providers can access my medical records?
- Can we meet with my family/Agent to talk about everyone's role in honoring my choices?

**Serious Advancing Illness Care Discussion Guide** offers some additional questions that go with basic discussion guide. Start with one or more questions that make sense to you, and write down your own questions below to bring to your next appointment.

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## **Things to Know About MOLST- Medical Orders for Life-Sustaining Treatment and CC/DNR -Comfort Care/Do Not Resuscitate Orders**

### **1. What is MOLST or Medical Orders for Life-Sustaining Treatment?**

MOLST is a medical order and form that communicates a patient's choices and preferences about life-sustaining treatment to his/her care providers. MOLST is based on an adult's right to information regarding the risks and benefits of life-sustaining treatments based on their current health condition, and to make informed choices to accept or refuse life-sustaining treatments.

### **2. Is MOLST a medical document or a personal care planning document?**

It's both. MOLST is a medical document and form that must be signed by your clinician to be valid, but as importantly, MOLST is also a personal care planning document. It's up to the patient or the patient's advocates whether to choose to complete a MOLST form as part of their personal health care plan.

### **3. Is the MOLST form for every adult?**

No. The MOLST form is intended to be used by adults with serious advancing illness.

### **4. How does the MOLST process work?**

A clinician or a patient or the patient's advocates can initiate a discussion about CPR and other life-sustaining treatments given the patient's current health condition. The discussion works like this:

- The patient receives information regarding the risks and benefits and expected outcomes of attempting CPR and life-sustaining treatments given his/her current health condition;
- The patient chooses what he/she wants for care and does not want for care;
- The patient and clinician can record the patient's choices on the MOLST form, choosing to fill out just the front side, or both the front and back sides of the form;
- The clinician and patient both sign the MOLST form, and the medical order becomes immediately effective and should be followed by care providers in all treatment settings.

### **5. Who can have a MOLST discussion and sign the MOLST form?**

A clinician and a patient or the patient's advocates can have a discussion, fill out and sign the MOLST form. The clinicians that have the authority to sign the form are physicians, nurse practitioners and physician assistants. A competent adult who has a serious advancing illness or medical frailty can have a discussion and sign the form, and a Health Care Agent can sign a MOLST form unless expressly limited to do so in the Health Care Proxy. The MOLST form states *"A Guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's legal authority."*

### **6. Who can make changes to the MOLST form or revoke/tear up a MOLST form?**

A competent adult can always make changes to his/her MOLST form or tear it up or make a new one. The MOLST form is personal and made to reflect a patient's current care choices and can be changed and added to as a patient's health needs and choices change over time. A **Health Care Agent** can make



changes, or request treatments that the patient or the Agent previously refused, or revoke/tear up the MOLST form, unless the Health Care Proxy expressly limits this power. The MOLST form states, “The patient or health care agent (if the patient lacks capacity) ... can revoke the MOLST form at any time and/or request previously refused medically-indicated treatment.”

**7. What happens after the clinician and patient sign a MOLST form?**

The original MOLST form stays with the patient, and a copy is placed in the patient’s medical record. Copies can be made and given to family, the Agent, and other care providers- anyone the patient chooses. The original MOLST form travels with the patient to any treatment settings.

**8. Are copies just as valid as the original MOLST form?**

Yes. Faxed copies or photocopies, in any color paper, are valid and should be honored.

**9. Who has to follow the decisions on the MOLST Form? What if there are two MOLST forms?**

All licensed health professionals (nurses, emergency responders, etc.) should honor a valid MOLST form. EMS (Emergency Treatment Services) personnel must follow the protocols that point to the MOLST form. If there are two MOLST forms, the most recently signed and dated document is valid.

**10. What is a Comfort Care/Do Not Resuscitate Order (CC/DNR)? What’s the difference between a CC/DNR and a MOLST form?**

A Comfort Care/Do Not Resuscitate Order is a medical form signed by a clinician after a discussion with a patient about the risks and benefits of CPR (Cardiopulmonary Resuscitation) given the patient’s medical outlook, where the patient chooses to have comfort care measures but not to receive CPR if the patient’s heart beat and breathing stop. The CC/DNR form only documents one decision- not to be resuscitated if your heart beat and breathing stop. The MOLST also form contains this decision, but the form gives you the choice to decide: Yes, I do want to be resuscitated or, No, I do not want to be resuscitated. Additionally, MOLST lets you document your preferences and choices about a range of other life-sustaining treatments that could be attempted in the course of your illness.

**11. Are the MOLST and CC/DNR forms both valid in Massachusetts?**

Yes. Both the MOLST and CC/DNR forms are considered valid and are to be followed by EMS (Emergency Treatment Services) and clinicians to honor the choices of the patient.

**12. What if a patient has both a CC/DNR form and a MOLST form?**

For cardiac/respiratory arrest, the most recent orders are followed, otherwise MOLST orders apply.

The MA MOLST website has comprehensive information for care providers and consumers. Educational brochures and sample forms are available in 9 languages. [www.molst-ma.org](http://www.molst-ma.org)



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| <b>MASSACHUSETTS MEDICAL ORDERS</b><br><b>for LIFE-SUSTAINING TREATMENT</b><br><b>(MOLST)</b> <a href="http://www.molst-ma.org">www.molst-ma.org</a> |  |
| Patient's Name _____<br>Date of Birth _____<br>Medical Record Number if applicable: _____  |   |

**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.

|   |   |
|---|---|
| <b>A</b>  | <b>CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest</b>  |
| Mark one circle →   | <input type="radio"/> Do Not Resuscitate <span style="margin-left: 200px;"><input type="radio"/> Attempt Resuscitation</span>   |
| <b>B</b>  | <b>VENTILATION: for a patient in respiratory distress</b>   |
| Mark one circle →   | <input type="radio"/> Do Not Intubate and Ventilate <span style="margin-left: 200px;"><input type="radio"/> Intubate and Ventilate</span>   |
| Mark one circle →   | <input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP) <span style="margin-left: 200px;"><input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)</span>   |
| <b>C</b>  | <b>TRANSFER TO HOSPITAL</b>   |
| Mark one circle →   | <input type="radio"/> Do Not Transfer to Hospital ( <i>unless needed for comfort</i> ) <span style="margin-left: 200px;"><input type="radio"/> Transfer to Hospital</span>  |
| PATIENT<br>or patient's<br>representative<br>signature<br><br><b>D</b><br><i>Required</i><br><br>Mark one circle and<br>fill in every line<br>for valid Page 1. | <b>Mark one circle below to indicate who is signing Section D:</b><br><input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor<br><br>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. <i>A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i><br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input checked="" type="checkbox"/> Signature of Patient (or Person Representing the Patient)                         </div> <div style="width: 35%;"> <input type="text"/> Date of Signature                         </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="text"/> Legible Printed Name of Signer                         </div> <div style="width: 35%;"> <input type="text"/> Telephone Number of Signer                         </div> </div> |
| CLINICIAN<br>signature<br><br><b>E</b><br><i>Required</i><br>Fill in every line for<br>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.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input checked="" type="checkbox"/> Signature of Physician, Nurse Practitioner, or Physician Assistant                         </div> <div style="width: 35%;"> <input type="text"/> Date and Time of Signature                         </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="text"/> Legible Printed Name of Signer                         </div> <div style="width: 35%;"> <input type="text"/> Telephone Number of Signer                         </div> </div>   |
| <b>Optional</b><br>Expiration date (if<br>any) and other<br>information   | This form does not expire unless expressly stated. <i>Expiration date (if any) of this form:</i> _____<br>Health Care Agent Printed Name _____ Telephone Number _____<br>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: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_ Medical Record # if applicable: \_\_\_\_\_

|  |   |  |  |
|--|---|--|--|
| <b>F</b>   | <b>Statement of Patient Preferences for Other Medically-Indicated Treatments</b>                                      |  |  |
|  | <b>INTUBATION AND VENTILATION</b>   |  |  |
|  | Mark one circle → <input 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<br><input type="radio"/> Did not discuss |
|  | <b>NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)</b>                                     |  |  |
|  | Mark one circle → <input 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<br><input type="radio"/> Did not discuss |
|  | <b>DIALYSIS</b>   |  |  |
| Mark one circle → <input type="radio"/> No dialysis  | <input type="radio"/> Use dialysis<br><input type="radio"/> Use dialysis, but short term only                         | <input type="radio"/> Undecided<br><input type="radio"/> Did not discuss                         |  |
| <b>ARTIFICIAL NUTRITION</b>  |   |  |  |
| Mark one circle → <input type="radio"/> No artificial nutrition  | <input type="radio"/> Use artificial nutrition<br><input type="radio"/> Use artificial nutrition, but short term only | <input type="radio"/> Undecided<br><input type="radio"/> Did not discuss                         |  |
| <b>ARTIFICIAL HYDRATION</b>  |   |  |  |
| Mark one circle → <input type="radio"/> No artificial hydration  | <input type="radio"/> Use artificial hydration<br><input type="radio"/> Use artificial hydration, but short term only | <input type="radio"/> Undecided<br><input type="radio"/> Did not discuss                         |  |
| Other treatment preferences specific to the patient's medical condition and care _____<br>_____<br>_____ |   |  |  |

|  |   |  |
|--|---|--|
| <b>PATIENT</b><br>or patient's<br>representative<br>signature<br><br><b>G</b><br><i>Required</i> | <b>Mark one circle below to indicate who is signing Section G:</b><br><input 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 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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i> |  |
| Mark one circle and fill in every line for valid Page 2.   | <input checked="" type="radio"/> Signature of Patient (or Person Representing the Patient) _____<br>Legible Printed Name of Signer _____  | Date of Signature _____<br>Telephone Number of Signer _____          |
|  | <b>CLINICIAN</b><br>signature<br><br><b>H</b><br><i>Required</i>  |  |
| Fill in every line for valid Page 2.   | <input checked="" type="radio"/> Signature of Physician, Nurse Practitioner, or Physician Assistant _____<br>Legible Printed Name of Signer _____   | Date and Time of Signature _____<br>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.*



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF EMERGENCY MEDICAL SERVICES

CCFORM\_INSERT  
2/2007

COMFORT CARE / DO NOT RESUSCITATE  
("DNR") ORDER VERIFICATION

|                                  |  |   |
|----------------------------------|--|---|
| PATIENT'S LAST NAME              |  |   |
| PATIENT'S FIRST NAME             |  |   |
| PATIENT'S MIDDLE NAME OR INITIAL |  |   |
| DATE OF BIRTH (MM/DD/YYYY)       |  | GENDER<br><input type="checkbox"/> M <input type="checkbox"/> F |

|                               |       |                               |
|-------------------------------|-------|-------------------------------|
| STREET OR RESIDENTIAL ADDRESS |       |                               |
| CITY                          | STATE | ZIP CODE (5 or 9 digits)<br>- |

|  |  |
|--|--|
| LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable) |  |
| FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT                |  |
| MIDDLE NAME OR INITIAL                                     |  |

|   |      |
|---|------|
| <b>PATIENT/GUARDIAN/HHEALTH CARE AGENT STATEMENT (SIGNATURE AND DATE REQUIRED)</b>  |      |
| I _____ ( <input type="checkbox"/> patient <input type="checkbox"/> guardian <input type="checkbox"/> health care agent)<br>verify that the above named patient has a current and valid Do Not Resuscitate order ("DNR order"). I understand that by signing this form, the DNR order, if current and valid, will be recognized in out-of-hospital settings and the COMFORT CARE / Do Not Resuscitate Order Verification Protocol will be followed by emergency medical services personnel. |      |
| Signature of Patient/Guardian/Health Care Agent   | Date |

|  |   |   |
|--|---|---|
| <b>PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICATION (PHYSICIAN / NP / PA SIGNATURE AND DATES ALWAYS REQUIRED)</b>   |   |   |
| I am an attending physician / NP / PA for the above named patient. I verify that the above named patient has a current and valid Do Not Resuscitate order, issued on _____   |   |   |
| This DNR order <input type="checkbox"/> does <input type="checkbox"/> does not    have an expiration date. If there is an expiration date, it is indicated below, and this verification form also expires on that date.  |   |   |
| I hereby direct that all emergency medical services personnel comply with the Massachusetts Department of Public Health, Office of Emergency Medical Services' COMFORT CARE / Do Not Resuscitate Order Verification Protocol with regard to the above named patient. |   |   |
| Signature of Physician / NP / PA   |   |   |
| Print Name of Physician / NP / PA  | Effective Date of CC / DNR Order Verification | Expiration Date (if any) of DNR Order and CC/DNR Order Verification |
| Address of Physician / NP / PA   |   |   |
| Telephone Number of Physician / NP / PA  |   |   |

| OPTIONAL BRACELET INSERTS  |           |       |   |
|--|-----------|-------|---|
| <b>Attention Physician/NP/PA</b><br>If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet.<br><b>Massachusetts</b><br><b>Comfort Care/DNR Order Verification</b> | Pat. Name | _____ | Gender    M <input type="checkbox"/> F <input type="checkbox"/> |
|  | Pat. DOB: | _____ | Expir. Date:    _____   |
|  | MD/NP/PA  | _____ | Signature    _____  |
|  |           |       |   |
| <b>Attention Physician/NP/PA</b><br>If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet.<br><b>Massachusetts</b><br><b>Comfort Care/DNR Order Verification</b> | Pat. Name | _____ | Gender    M <input type="checkbox"/> F <input type="checkbox"/> |
|  | Pat. DOB: | _____ | Expir. Date:    _____   |
|  | MD/NP/PA  | _____ | Signature    _____  |
|  |           |       |   |
| <b>Attention Physician/NP/PA</b><br>If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet.<br><b>Massachusetts</b><br><b>Comfort Care/DNR Order Verification</b> | Pat. Name | _____ | Gender    M <input type="checkbox"/> F <input type="checkbox"/> |
|  | Pat. DOB: | _____ | Expir. Date:    _____   |
|  | MD/NP/PA  | _____ | Signature    _____  |
|  |           |       |   |
| <b>Attention Physician/NP/PA</b><br>If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet.<br><b>Massachusetts</b><br><b>Comfort Care/DNR Order Verification</b> | Pat. Name | _____ | Gender    M <input type="checkbox"/> F <input type="checkbox"/> |
|  | Pat. DOB: | _____ | Expir. Date:    _____   |
|  | MD/NP/PA  | _____ | Signature    _____  |
|  |           |       |   |

## Things to Know About Palliative Care

### What is Palliative Care?

Palliative Care is specialized medical care for individuals diagnosed with serious illness which helps to relieve the symptoms, pain and stress of living with a serious illness. The goal of palliative care is to manage pain and symptoms, provide emotional support to the patient and family, and improve an individual's quality of life.

### Can anyone with a serious illness ask for Palliative Care?

Yes. Anyone with a serious illness seeking relief from symptoms, pain and stress can ask their doctor for palliative care. Serious illness may include cancer, respiratory diseases, heart disease, Alzheimer's Disease, HIV/AIDS, kidney failure, multiple sclerosis, and more. Palliative care can be effective at any age, whether you are receiving curative treatments, living with serious chronic illness, or coping with serious advancing illness and end of life care.

### When can I ask my doctors for Palliative Care?

Anytime. You or a family member can ask for palliative care when first diagnosed and all throughout a serious illness. It can help with aggressive treatments when working towards a cure or remission of an illness. If serious illness is not or no longer curative, palliative care can be supportive to help control the progression of the illness, manage symptoms, and improve quality of life. It can help make everyday life the best it can be.

### How does Palliative Care work?

Every person with a serious illness can experience the pain and symptoms of their disease differently. A palliative care clinician or team, works together with a patient's regular doctor to find the source of the problem. The clinician or team will offer the patient options for the best possible treatments to help lessen or control pain, and improve symptoms such as shortness of breath, nausea, loss of appetite, fatigue, trouble sleeping. Additionally, palliative care typically offers the patient, family and caregivers emotional and spiritual support.

### Where can I get it and how do I pay for it?

Most adults can receive palliative care where they live or receive care. Many insurance plans cover all or part of palliative care. However, palliative care can vary as to who provides it in your community, what services they offer, and how to pay for care. Ask your primary care doctor or specialist about the type of care that may be best given your illness and treatment choices.

### What's the difference between Palliative Care and Hospice Care?

Palliative Care is for individuals at any age or phase of health living with a serious illness. Hospice Care is a benefit you receive from Medicare when your doctor determines your life expectancy is 6 months or less. Often people receiving hospice care receive palliative care to relieve symptoms, pain and stress, and to offer emotional and spiritual support. Having palliative care at this phase of health can improve the quality of everyday life, and for some, increase life expectancy.



## **Things to Know: The 5 W's About Hospice Care**

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### **WHO is eligible for hospice?**

Hospice serves patients with a terminal illness resulting in a life expectancy of six months or less, as determined by the patient's physician. Care is provided regardless of diagnosis, age, gender, nationality, race, creed, sexual orientation, disability or ability to pay. The patient makes the decision to choose hospice in partnership with his or her family physician and the hospice team, after a thorough review of all the care options.

### **WHEN is it time for hospice?**

When the goal of treatment begins to shift from curing the illness to providing comfort, it is time to consider hospice. This time may come well before a physician indicates that the patient's life expectancy is six months or less. Sadly, many people wait until their final days to involve hospice. By contacting hospice early in the diagnosis, the patient and family reserve time to understand their options and choose the path that will have the most positive impact on quality of life. The best time to learn about hospice is before you need it.

### **WHY should we choose hospice?**

The decision to choose hospice is a very personal one. It directly involves the patient, family, physician and any loved ones who may serve as caregivers. Here are a few things you should consider. Hospice's expertise in palliative, or "comfort" care, assures the patient of state-of-the-art pain control and symptom management. Hospice enables patients to focus on living their remaining days fully, at home, among family and friends. This emphasis on family involvement - understanding that everyone's definition of "family" is unique - helps individuals to support each other during this time of life.

### **WHERE is hospice care provided?**

Hospice care takes place in the home. For some, "home" may mean a house or an apartment. For others, it may be some form of extended care facility, such as a nursing home or assisted living residence. In addition, there are several hospice residences operating in Massachusetts exclusively for hospice patients. Regardless of your circumstance, the hospice team will come to you where you live. Hospice patients who live in their own home often have the help of a family member or friend who serves as the "primary caregiver". This caregiver works closely with the hospice team to provide for the patient's daily needs. In extended care facilities, hospice teams create a partnership with the staff and family, just as they would with the family in the home. In addition to home care, hospice provides short-term inpatient hospital care when necessary to manage the symptoms of the illness or to give the family a brief rest from the responsibilities of care giving.

### **WHAT makes hospice care unique?**

Hospice care centers around the patient and family. The goal of the professional hospice team is to empower you to make your own choices with its support and assistance. The team serves as your advocates, helping you to access the information and resources you need during this very challenging time. Hospice recognizes that the family and caregivers need an extra measure of support both during and after their experience of caring for a terminally ill patient.