

“Supplemental” Documentation Form for ADULTS

For Do-Not-Resuscitate (DNR) Orders

For MOLST Program

Medical Orders for Life-Sustaining Treatment

**Do-Not-Resuscitate (DNR) and
other Life-Sustaining Treatments (LST)**

Complete all Sections that Apply:

Section 1: Adult Patients/Residents Who Lack Capacity to Consent

Section 2: Exceptional Circumstances

2A: Therapeutic Exception

2B: Medical Futility and No Surrogate

2C: Residents of OMH and OMRDD Facilities

2D: Residents of Correctional Facilities

Last Name/First/Middle Initial of Patient/Resident

Address

City/State/Zip

Patient/Resident Date of Birth
(mm/dd/yyyy)

Gender M F

Unique Patient Identifier (Last 4 SSN)

Note: Actual orders should be placed on the MOLST form. No additional documentation beyond the MOLST form is needed for adult patients who are able to consent for themselves (when not residents of OMH, OMRDD, or Correctional Facilities.) New York State Public Health Law requires capacity assessment and documentation prior to issuing a DNR order. The physician is responsible for completing both the MOLST and this documentation form (under the circumstances outlined above), and for obtaining the additional consultations and signatures where indicated. These forms must be placed in the medical record. *This documentation is not required if CPR order is chosen.*

WARNING: If patient lacks medical decision-making capacity as a result of mental retardation or developmental disability or has a legal guardian, specific, mandatory procedures need to be followed. Review information and seek legal counsel.

Section 1

Complete Steps 1-9 for adult patients/residents who lack capacity to consent:

Step 1: Physician determination of lack of capacity:

If the patient lacks capacity because of a mental illness as defined by OMH (this does not include dementia), the concurring physician must be board certified or board eligible in psychiatry. If the patient lacks capacity because of a developmental disability, the concurring opinion must be rendered by a physician or psychologist with special experience or training in the field of developmental disabilities.

I have examined the patient/resident and his/her medical record, and have determined that the patient/resident lacks the ability to understand and appreciate the nature and consequences of a DNR order, including benefits and burdens of such an order, and to reach an informed decision regarding the order. (Check if applicable)

Describe the cause, nature and extent of the lack of capacity: _____

Probable duration: _____

Step 2: Patient/Resident notice of the determination that he or she lacks capacity:

(Check one)

a. I have not provided this notice because the patient/resident has not given any indication of the ability to comprehend his or her lack of capacity.

b. I have provided notice about lack of capacity directly to the patient/resident.

Step 3: Physician determination of lack of utility for cardiopulmonary resuscitation:

This step is not required if consent to DNR is by a health care agent.

A surrogate may only consent to a DNR for a patient/resident with mental retardation or developmental disability following a determination by two physicians that one of the following criteria is met.

I have examined the patient/resident and his/her medical record, and have determined to a reasonable degree of medical certainty that: (Check all that apply)

a. The patient/resident has a terminal condition

b. The patient/resident is permanently unconscious

c. Resuscitation would be medically futile

d. Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident’s medical condition and the expected outcome of resuscitation

SECTION 1

Step 4: Surrogate Selection: The physician must determine who the proper surrogate is for the purposes of helping with medical decisions for the patient/resident who lacks capacity, including DNR decisions and other treatments covered in the MOLST Form. For a DNR decision, the surrogate must be selected from the following list in order of priority: (please check which one is selected)

- 1. Patient/resident designated health care agent
- 2. Court-appointed committee or guardian of the patient/resident
- 3. Patient/resident's spouse
- 4. Patient/resident's son or daughter, age 18 or older
- 5. Patient/resident's parent
- 6. Patient/resident's brother or sister, age 18 or older
- 7. Patient/resident's close friend, age 18 or older (affidavit of close friend required; see below)
- 8. No appropriate surrogate decision-maker is available (go to Section 2B: Medical Futility)

Print name of designated surrogate: _____
Relationship to patient/resident: _____

Step 5: Surrogate consent:

Be sure to complete the subsection of B on page 1 of the MOLST form.

Step 6: Patient/resident notice of the determination that surrogate has signed a DNR order on the patient/resident's behalf (please check one):

- a. I have not provided notice because the patient/resident has not given any indication of the ability to comprehend this DNR decision.
- b. I have not provided notice because the patient/resident would suffer immediate and severe injury from a DNR discussion.
- c. Neither a or b above apply, so I have provided notice that a surrogate has authorized a DNR decision directly to the patient/resident.

Step 7: Affidavit of close friend (applies only if a close friend is selected as surrogate, otherwise skip)

I, _____, hereby state under penalty of perjury that I am a close friend of _____ (the patient/resident), have maintained regular contact with the patient/resident, and am familiar with the patient/resident's activities, health, and religious or moral beliefs.

I am familiar with these matters regarding the patient/resident as a result of:

Signature of Close Friend: _____ **Print Name:** _____

S
E
C
T
I
O
N

1

“Supplemental” Documentation Form for ADULTS

For Do-Not-Resuscitate (DNR) Orders

For MOLST Program

Medical Orders for Life-Sustaining Treatment

**Do-Not-Resuscitate (DNR) and
other Life-Sustaining Treatments (LST)**

Last Name/First/Middle Initial of Patient/Resident
Address
City/State/Zip
Patient/Resident Date of Birth (mm/dd/yyyy)
Gender <input type="checkbox"/> M <input type="checkbox"/> F
Unique Patient Identifier (Last 4 SSN)

S
E
C
T
I
O
N

1

Step 8: Physician certification and signature:

I certify that I have examined the patient/resident and his/her medical record, and that I have reviewed and completed steps 1-6 on this document, supporting my writing a do-not-resuscitate order on the MOLST form in this patient/resident’s medical record.

_____	_____	_____
Physician Signature	Print Name	Date

Step 9: Concurring physician certification and signature for lack of utility of CPR and capacity determination because of developmental disability:

If the patient lacks capacity because of a mental illness as defined by OMH (this does not include dementia), the concurring physician must be board certified or board eligible in psychiatry. If the patient lacks capacity because of a developmental disability, the concurring opinion must be rendered by a physician or psychologist with special experience or training in the field of developmental disabilities.

I certify that I have examined the patient/resident and his/her medical record, and I have reviewed **Steps 1 and 3** in this form (determination of lack of decision-making capacity and certification of lack of utility of cardio-pulmonary resuscitation), supporting, with a reasonable degree of medical certainty, the physician writing a do-not-resuscitate order on the MOLST form in this patient/resident’s medical record.

_____	_____	_____
Concurring Physician Signature of lack of utility of CPR	Print Name	Date
_____	_____	_____
Concurring Physician/Psychologist Signature re: capacity determination	Print Name	Date

Section 2: Exceptional Circumstances

(Note: Complete each section only if it applies)

- 2A: Therapeutic Exception***
- 2B: Medical Futility and No Surrogate***
- 2C: Residents of OMH and OMRDD Facilities***
- 2D: Residents of Correctional Facilities***

*** Under these exceptional circumstances, please send Supplemental MOLST Documentation Form along with MOLST Physician Order Form when patient/resident is changing facilities.**

S
E
C
T
I
O
N

2

2A: Therapeutic Exception (for patient/resident with capacity who would suffer immediate and severe harm by a discussion about DNR):

Three conditions must apply when invoking the therapeutic exception:

- i) State the reasons why harm would result from informing the patient/resident
- ii) Make every effort to ascertain the patient/resident’s wishes and values about DNR
- iii) Obtain consent from surrogate according to Section I – Step 5 above.

State reasons for invoking the therapeutic exception: _____

I have personally examined the patient/resident, and have determined to a reasonable degree of medical certainty that the patient/resident would suffer immediate and severe harm from discussion of DNR.

Physician signature: _____	Date: _____
Print name: _____	
Concurring physician signature: _____	Date: _____
Print name: _____	

2B: Medical Futility Exception: (required to issue a DNR order for an adult patient/resident without capacity who has no surrogate)

We have personally examined the patient/resident and have determined with a reasonable degree of medical certainty that any attempt to perform cardiopulmonary resuscitation on this adult patient/resident would be medically futile.

Physician signature: _____ Print Name: _____ Date: _____

Concurring physician: _____ Print Name: _____ Date: _____

(Note: Unless cardiopulmonary resuscitation would be medically futile, a court order is required to issue a DNR order for a patient/resident without capacity and no surrogate. If this attestation regarding medical futility cannot be made, consult legal counsel.)

2C: Residents of OMH and OMRDD Facilities – Additional requirements for residents from facilities operated or licensed by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities:

I notified the director of the facility from which the patient/resident was transferred of:

- a. _____ the determination that the patient/resident lacks capacity (if applicable, complete Section 1)
- b. _____ the patient/resident's or representative's consent to a DNR order

Name of facility notified: _____

Print name of person notified: _____

Physician signature: _____ Print Name: _____ Date: _____

2D: Residents of Correctional Facilities - Additional Requirements:

I notified the director of the correctional facility from which the patient/resident was transferred of:

- a. _____ the determination that the patient/resident lacks capacity (if applicable, complete Section 1)
- b. _____ the patient/resident's or representative's consent to a DNR order

Name of facility notified: _____

Print name of person notified: _____

Physician signature: _____ Print Name: _____ Date: _____