Durable Power of Attorney for Healthcare Statutory Form

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make healthcare decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other healthcare decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and healthcare necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make healthcare decisions for you if your agent:

(1) Authorizes anything that is illegal,
(2) Acts contrary to your known desires, or
(3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your family or next of kin of your desire, if any, to be an organ and tissue owner.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other healthcare provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. This document revokes any prior durable power of attorney for healthcare.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your healthcare. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

(1) DESIGNATION OF HEALTHCARE AGENT. I, (insert your name and address below)

First Name Middle Name Last Name

Address: City/State/Zip

Do hereby designate and appoint:

(insert name, address, and telephone number of one individual only as your agent to make healthcare decisions for you. None of the following may be designated as your agent:
(1) your treating healthcare provider, (2) a nonrelative employee of your treating healthcare provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.) as my attorney in fact (agent) to make healthcare decisions for me as authorized in this document. For the purposes of this document, "healthcare decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.)

Name: Address:

Phone: City/State/Zip

(2) CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTHCARE. By this document I intend to create a durable power of attorney for healthcare.

(3) GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make healthcare decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures and informing my family or next of kin of my desire, if any, to be an organ or tissue donor.

(If you want to limit the authority of your agent to make healthcare decisions for you, you can state the limitations in paragraph (4) ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

(4) STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make healthcare decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your healthcare. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make healthcare decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for healthcare, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:
(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

(b) Additional statement of desires, special provisions, and limitations regarding healthcare decisions:

_____

(c) Statement of desire regarding organ and tissue donation:

_____

Initial if applicable:

_____ In the event of my death, I request that my agent inform my family/next of kin of my desire to be an organ and tissue donor, if possible.

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

(5) INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph (4) ("Statement of desires, special provisions, and limitations") above.)

(6) SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the healthcare decisions that my agent is authorized by this document to

make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

(7) DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for healthcare expires on: _____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

(8) DESIGNATION OF ALTERNATE AGENTS. (You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph (1), above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph (1) is not available or becomes ineligible to act as my agent to make a healthcare decision for me or loses the mental capacity to make healthcare decisions for me, or if I revoke that person's appointment or authority to act as my agent to make healthcare decisions for me, then I designate and appoint the following persons to serve as my agent to make healthcare decisions for me as authorized in this document, such persons to serve in the order listed below:

(A) First Alternate Agent: (Insert name, address, and telephone number of first alternate agent.)

_____

(B) Second Alternate Agent: (Insert name, address, and telephone number of second alternate agent.)

_____

(9) PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for healthcare.

DATE AND SIGNATURE OF PRINCIPAL (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Healthcare on (Enter date) at (Enter City) (Enter State)

(You sign below)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY ONE NOTARY PUBLIC OR TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

(1) A person you designate as your agent or alternate agent,
(2) A healthcare provider,
(3) An employee of a healthcare provider,
(4) The operator of a community care facility,
(5) An employee of an operator of a community care facility.

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a healthcare provider, an employee of a healthcare provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Option 1 – Two (2) Qualified Witnesses:

Signature: Residence Address:

Print Name: Date:

Signature: Residence Address:

Print Name: Date:

Option 2 – One Notary Public Signature

Signature: , Notary Public

Print Name: Date:

My commission expires on:

(AT LEAST ONE OF THE ABOVE WITNESSES OR THE NOTARY PUBLIC MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:

Print Name:

DECLARATION

I, ..., being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare: if I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization includes ☐ does not include ☐ the withholding or withdrawal of artificial feeding (check only one box in this sentence).

Signed this ..... day of ....., ...

.....	.....
Declarant Signature	Declarant Name
.....	
.....	
Declarant Address	

The Declarant is personally known to me and voluntarily signed this document in my presence.

.....	.....
Witness 1 Signature	Witness 2 Signature
.....	.....
Witness 1 Name	Witness 2 Name
.....	.....
.....	.....
Witness 1 Address	Witness 2 Address

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY.
MOLST IS VOLUNTARY. NO PATIENT IS REQUIRED TO COMPLETE A MOLST FORM.

Medical Orders for Life Sustaining Treatment (MOLST)

Follow these orders, then contact a MOLST-Qualified Health Care Provider. This is a **Medical Order Sheet** based upon the person's wishes in his/her current medical condition. Any section not completed implies full treatment. **This MOLST remains in effect unless revised.**

Patient's Last Name _____ Patient's First Name _____

Gender: ☐ M ☐ F Patient's Date of Birth / / Date/Time Form Prepared _____

A — CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and is not breathing.*

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When not in cardiopulmonary arrest, follow orders in sections B and C.

B* — CHECK ONE

MEDICAL INTERVENTION: *Patient has a pulse and/or is breathing.*

☐ **Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ **Full Treatment:** Includes care described above in Comfort Measures Only and Limited Additional Interventions, as well as additional treatment, such as intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated.

C — CHECK ONE

TRANSFER TO HOSPITAL

☐ Do not transfer to hospital for medical interventions.

☐ Transfer to hospital if comfort measures cannot be met in current location.

D — CHECK ONE

ARTIFICIAL NUTRITION (For example a feeding tube): *Offer food by mouth if feasible and desired.*

☐ No artificial nutrition
☐ Long-term artificial nutrition, if needed
☐ Defined trial period of artificial nutrition
☐ Artificial nutrition until not beneficial or burden to patient

E — CHECK ONE

ARTIFICIAL HYDRATION: *Offer fluid/nutrients by mouth if feasible and desired.*

☐ No artificial hydration
☐ Long-term artificial hydration, if needed
☐ Defined trial period of artificial hydration
☐ Artificial hydration until not beneficial or burden to patient

F

ADVANCE DIRECTIVE (if any): *Check all advance directives known to be completed.*

☐ Durable Power of Health Care ☐ Health Care Proxy ☐ Living Will ☐ Documentation of Oral Advance Directive

Discussed with:

☐ Patient ☐ Health Care Decision Maker ☐ Parent/Guardian of Minor ☐ Court-Appointed Guardian ☐ Other: _____

G

SIGNATURE OF MOLST-QUALIFIED HEALTHCARE PROVIDER (Physician, RNP, APRN, or PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Signature (required) _____ Phone Number _____ Date/Time / /

Print Name _____ Rhode Island License # _____

SIGNATURE OF PATIENT, DECISION MAKER, PARENT/GUARDIAN OF MINOR, OR GUARDIAN

By signing this form, the patient or legally-recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (Required) _____ Phone Number _____ Relationship (if patient, write self) _____

Print Name and Address _____

SEND MOLST FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY.
MOLST IS VOLUNTARY. NO PATIENT IS REQUIRED TO COMPLETE A MOLST FORM.

Review and Renewal of MOLST Orders on This MOLST Form (this MOLST form remains in effect unless another MOLST form is executed.)

The MOLST-Qualified Health Care Provider may 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 (positive or negative); or
- If the patient or other decision-maker changes his/her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, Nursing Home, Provider's Office, Patient's Residence)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form

Directions for MOLST-Qualified Health Care Providers Completing MOLST

- Must be completed by a MOLST-Qualified Health Care Provider based on patient preferences and medical indications. A MOLST-Qualified Health Care Provider is defined as a physician, nurse practitioner, advanced practice registered nurse, or a physician assistant.
- MOLST must be signed by a MOLST-Qualified Healthcare Provider (physician, nurse practitioner, advanced practice registered nurse, or physician assistant) and the patient/decision maker to be valid. Verbal orders are acceptable with follow-up signature by provider in accordance with facility/community policy and documentation that there was discussion with the patient or the patient's advocate about discontinuing the MOLST order.)
- This is the ONLY MOLST FORM that is acceptable for completion in Rhode Island. Do not make your own MOLST form. Photocopies and faxes of signed MOLST forms are legal and valid.
- Any incomplete section of the MOLST form implies full treatment for that section.

*Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture)
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Modifying and Voiding MOLST

- A patient with capacity can, at any time, void the MOLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new MOLST form.
- To void MOLST draw a line through Sections A through E and write "VOID" in large letters. Sign and date the line.
- A health care decision maker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

DEFINITIONS

"Medical orders for life sustaining treatment" or "MOLST" means a voluntary request that directs a health care provider regarding resuscitative and life-sustaining measures. Rhode Island General Laws §23-4.11-2 (10).

"Qualified patient" means a patient who has executed a declaration in accordance with this chapter and who has been determined by the attending physician to be in a terminal condition. Rhode Island General Laws §23-4.11-2 (16).

"Terminal condition" means an incurable or irreversible condition that, without the administration of life sustaining procedures, will, in the opinion of the attending physician, result in death." Rhode Island General Laws §23-4.11-3.1 (20).

This form is approved by the Rhode Island Department of Health. For more information or a copy of the form, visit **www.health.gov**

SEND MOLST FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.
Rhode Island General Laws §23-4.11-3.1 authorizes this MOLST form. **(Rev. 9-2013)**