Medical Orders for End-of-life Intervention (MOELI)-R3

MOELI is a set of medical orders that guide medical treatment based on your treatment preferences: it *must be signed by a qualified provider*. ** It is voluntary. **MOELI supplements but does not replace a living will. **You and/or your legal surrogate must participate in its completion, *jointly when possible.* ** You can accept or refuse treatment as long as you have capacity--MOELI will be used only when you cannot decide for yourself. **You should discuss this MOELI with your healthcare providers during medical visits and request changes if your preferences change.

Patient name: Last_____ First_____ Middle_____

Date of birth:_____ Last 4 #SSN____ ____ ____ ____ Gender: __M __F ___Other (specify)_____

A Reason for MOELI: (Choose ONE)

__ I am >18 years old and want my wishes entered in my electronic medical record to protect my preferences, regardless of my age and current Health. I reserve the right to review and revise this document at will, as long as I have the mental capacity to do so. If required, I am:

__ 80 or older __Extremely frail __Death likely in 12 months ____Terminal illness(s), if any (specify)_____

B MOELI discussed with:

____Patient ……>
___ Spouse ……>
____Healthcare representative (surrogate)…….>
___ Domestic partner ……...…>
____Other (who?_____...>
____Legal guardian…… >
____Parent of a minor……>

C Legal capacity, health literacy, numeracy

___Yes __No __Not assessed
___Yes __No __Not assessed
___Yes __No __Not assessed
___Yes __No __Not assessed
___Yes __No __Not assessed
___Yes __No __Not assessed
___Yes __No __Not assessed

If patient did not participate, reason:

D Does patient have a living will (LW)?

_____Yes _____No
If yes: Date: _____
Was the LW discussed in creating the MOELI? ____Yes ____No
If living will exists, attach it to, and forward with, this MOELI.

If no living will, did you encourage patient to create one. ___Yes ___No ___N/A

E Patient's goal

____I wish to live as long as possible. Please prolong my life using all reasonably practical means.
____I wish to live a meaningful life. Please use life supports only as long as I am able to communicate and think clearly and my pain is controlled.
____I wish to experience a natural death. Please do not use artificial means to prolong my life.

F Cardiopulmonary Resuscitation (CPR)

____ DO attempt to resuscitate any time my heart stops beating (ACPR)
____ DO NOT attempt to resuscitate me EXCEPT if my heart stops beating due to correctable event in the judgment of providers at the scene (DNAR-X)
____ DO NOT resuscitate or use defibrillator under any circumstance. Always allow natural death (DNR)

G Medical Intervention

_____Full Treatment to prolong life by all medically effective means. Includes transfer to hospital or skilled nursing facility, resuscitation, ventilation, hydration and nutrition by tube, dialysis, all forms of breathing assistance, antibiotics and all other recommended procedures, drugs, and surgery.
____Always OR ____For a trial period of, or until_____
_____Limited Treatment of medical conditions that avoids burdensome methods. Includes transfer to hospital or skilled nursing facility, resuscitation, fluids and nutrition by tube, and medication including antibiotics and other drugs to relieve pain and symptoms, noninvasive breathing aids, but no surgery
____Always OR ____For a trial period of, or until_____
_____Comfort-focused treatment to maximize comfort. Includes medication to relieve pain and suffering, breathing enhanced with oxygen, suctioning and other means of clearing airways, and positioning for comfort. Does not include resuscitation or other life-prolonging procedures such as fluids and food by tube or dialysis. May include transfer to a hospital or skilled nursing facility if needed for comfort including pain relief.
Additional orders on reverse: ____Yes ____No

H OPTIONAL I hold blameless any provider who honors the requests herein in a manner that meets the community standard of care, and I direct my healthcare representative to do the same. (Patient's initials)_____

I Completion of this MOELI was facilitated by: Name:_____ Phone:_____E-mail_____

Provider

I verify that this document accurately summarizes patient's wishes
Print Name:_____
Signature:_____
___ Physician ___ARNP ___NP ___PA-C
Date_____Phone_____
E-mail_____

Patient

Print Name:_____
Signature:_____
Date_____Phone_____
E-mail_____

Surrogate

DPOAH? ___Yes ___No
Legal Guardian? ___Yes ___No
Signer understands and agrees to represent patient's preferences.
Name:_____
Signature:_____
Date_____Phone_____
E-mail_____

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed MOELI forms are legal and valid.

For more information contact: _____

J. Additional Orders Do you understand the likely benefits and risks of the following life-prolonging options?		**Use each: A**-Always want this procedure when prescribed. **BT**-Want it for a brief trial to treat a short-term problem, e.g. after surgery, sudden illness like stroke, or accident **N** Never want this procedure used. Other—specify conditions (CIRCLE ONE CHOICE)
1. Defibrillation	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
2. Mechanical respiration	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
3. Nutrition by tube	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
4. Fluids by tube	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
5. Dialysis	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
6. Pacemaker	___Yes ___No	**Always___ Brief trial___ Never____ Other:**
7. Antibiotics	___Yes No	**Always___ Brief trial___ Never____ Other:**
8. Other		

K. Review of this MOELI form

1. This MOELI should be reviewed periodically, and always when:
    a. Declarer is transferred from one care setting or one care level to another, or
    b. There is a substantial change in the declarer's health status, or
    c. The declarer's treatment preferences change
    d. It has been in effect for one year or more.
2. A competent adult, or the surrogate of a declarer who is not competent, can void this form and request alternative treatment.
3. To void this form, draw a line through "MEDICAL ORDERS" and write "VOID" in large letters.
4. Any changes require a new MOELI with mandatory signatures.

Review Date	Reviewer/Phone and/or e-mail.	Reason: Transfer, Changed health status, Routine review, Other	Review Outcome
			___No change ___Form voided ___New form completed
			___No change ___Form voided ___New form completed
			___No change ___Form voided ___New form completed
			___No change ___Form voided ___New form completed
			___No change ___Form voided ___New form completed
			___No change ___Form voided ___New form completed

L. Instructions for Completing the MOELI

1. Verify declarer is 18 or older, Note extreme frailty or specify illness(es) if any.
2. List all participants in discussion of this MOELI, ideally at least declarer and proxy.
3. Evaluate all participants' legal capacity, health literacy, and numeracy to make certain that they understand the meaning of all medical terms and the likely consequences of all decisions.
4. At declarer's request, include selected relatives in the discussion to facilitate family-centered decision making.
5. Review any existing living wills or MOELIs. The MOELI implements but does not replace living wills.
6. Solicit and record declarer's goals regarding length and quality of life.
7. Explain and record declarer's resuscitation preference.
8. Explain and record declarer's scope/type of intervention preference.
9. Explain optional waiver to protect providers who honor the expressed requests.
10. Obtain required signatures and assurances.
11. Review requests for specific interventions in Section J.
12. Record dates that MOELI has been reviewed, if any.

M. Using the MOELI

1. Any incomplete section implies full treatment for this section.
2. The MOELI is valid in all community and institutional settings until replaced by new medical orders
3. This MOELI is a set of medical orders that replaces all previous orders. Destroy all earlier orders.
4. This MOELI and attached documents should be transferred with declarer when changing providers or institutions

N. Space for logo and contact information of issuing organization.