CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

**CARE BRAVELY**

**To:** **Our Medicare Patients:**

**Subject:** **Medicare Annual Wellness and Other Preventive Visits**

Medicare covers an "Annual Wellness Visit" in addition to the one-time "Welcome to Medicare" exam. The "Welcome to Medicare" exam occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" exam.

| | |
|---|---|
| Initial Preventive Physical Exam (IPPE) | "Welcome to Medicare" is only for *new* Medicare patients. This must be done in the 1st year as a Medicare patient. |
| Annual Wellness Visit, Initial | At least 1 yr after the "Welcome to Medicare" exam. |
| Annual Wellness Visit, Subsequent | Once a year (more than 1 yr + 1 day after the last Wellness Visit). |

The Annual Wellness Visit is **not** the same thing as what many people often refer to as their yearly physical exam. **Medicare is very specific** about what the "Annual Wellness Visit" includes and excludes.

At the Annual Wellness Visit, your doctor and his staff will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The cost of the Annual Wellness Visit is fully covered by Medicare, without any co-pay due from you. We believe this is an important part of your health maintenance and quality of life.

The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule a separate visit to address those issues *or* your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit, if they are performed during the same visit.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this no-cost benefit to work with your physician in creating your personalized prevention plan.

*See the attached list to bring with you to your appointment.*

*What you should bring to your Annual Wellness Visit:*

The names of all your doctors:

| Name | Specialty |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

A list of all your medications

| Name of medicine | Dose (if you remember) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Have any of your close relatives had any health changes? ☐ Yes ☐ No

Has your mood changed? ☐ Yes ☐ No

Do you worry about falling? ☐ Yes ☐ No

Are you worried about your memory? ☐ Yes ☐ No

Are there any preventive tests you have done recently? (such as lab tests, mammograms, x-rays) ☐ Yes ☐ No

Have you had any recent immunizations? ☐ Yes ☐ No

Do you have a living will or advance directive? (If you have one, *please bring a copy of it with you.*) ☐ Yes ☐ No

***Complete and bring any additional worksheets included with this letter.***

Name:_____ Date:_____ Date of Birth:_____

# A Checklist for Your Medicare Wellness Annual Visit

*Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.*

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

| | Yes | No |
|---|---|---|
| 6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car? | ☐ | ☐ |
| 7. Can you shop for groceries or clothes without help? | ☐ | ☐ |
| 8. Can you prepare your own meals? | ☐ | ☐ |
| 9. Can you do your own housework without help? | ☐ | ☐ |
| 10. Can you handle your own money without help? | ☐ | ☐ |
| 11. Do you need help eating, bathing, dressing, or getting around your home? | ☐ | ☐ |

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well - could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad - could hardly be worse

14. Are you having difficulties driving your car?

- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

| | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Fall or dizzy when standing up | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Trouble eating well | ☐ | ☐ | ☐ | ☐ | ☐ |
| Teeth or dentures | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems using the telephone | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tired or fatigued | ☐ | ☐ | ☐ | ☐ | ☐ |

17. Have you fallen 2 or more times in the past year?

☐ Yes ☐ No

18. Are you afraid of falling?

☐ Yes ☐ No

19. Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?

- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much.

22. Have you been given any information to help you with the following:

- Hazards in your house that might hurt you?
  ☐ Yes ☐ No
- Keeping track of your medications?
  ☐ Yes ☐ No

23. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems.

How old are you? ☐ 65-69 ☐ 70-79 ☐ 80 or older

Are you male or female? ☐ Male ☐ Female

What is your race? (check one or more than one)

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other

## WOMEN'S PREVENTIVE WELLNESS PLAN

Patient Name Date

| Preventive Service | Frequency | Last Done |
|---|---|---|
| **Body Mass Index (BMI)____ Height _____ Weight _____** | **Annually** | |
| **Blood Pressure _____/_____** | • **Every 2 yrs, if BP </= 120/80 mm hg;**<br>• **Annually, if BP >120-139/80-89 mm hg** | |
| **Vision** | • **Every 3 yrs up to age 40;**<br>• **Every 2 yrs aged 40+** | |
| **Breast Cancer Screening (Mammogram)** | • **Every 2 yrs, aged 50-74 yrs** | |
| **Cervical Cancer Screening (Pap Smear)** | • **Every 3 yrs, aged 21-64 yrs;**<br>• **Every 5 yrs, aged 30-65 with HPV testing** | |
| **Osteoporosis Screening (Bone Density Measurement)** | • **Routinely, for women aged 65+**<br>• **Routinely, for women aged 60-64 with risk factors** | |
| **Cholesterol Testing** | **Regularly beginning at age 20 with risk factors** | |
| **Diabetes Screening** | **With a sustained BP >/= 135/80 mm Hg** | |
| **Colorectal Cancer Screening** | • **Annually, Fecal Occult Blood Stool (FOBS);**<br>• **Every 5 yrs, Sigmoidoscopy with FOBS;**<br>• **Every 10 yrs, Colonoscopy** | |
| **Sexually Transmitted Diseases (STD's)** | **As necessary for those with risk factors** | |
| **Depression Screening** | **As necessary for those with risk factors** | |
| **Alcohol Misuse Screening** | **As necessary for those with risk factors** | |
| **Immunizations:**<br>**Pneumococcal (Pneumonia) Vaccine**<br>**Influenza (Flu) Vaccine** | • **Pneumonia: 1-2 doses up to age 64;**<br>• **Pneumonia: 1 dose age 65+**<br>• **Influenza: Annually** | |
| **Other** | | |

**Your major risk factors:**

**Family history of _____ Obesity_____ Diabetes_____**
**Hypertension_____ Fall Risk_____ Smoking Use_____ Other_____**

**Recommendations for improvement:**

**Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____**

**Referrals**

For Staff Use: *[list handouts, referrals, or other followup instructions here]*

## MEN'S PREVENTIVE WELLNESS PLAN

Patient Name Date

| Preventive Service | Frequency | Last Done |
|---|---|---|
| **Body Mass Index (BMI)____**<br>**Height _____**<br>**Weight _____** | **Annually** | |
| **Blood Pressure _____/_____** | • **Every 2 yrs, if BP </= 120/80 mm hg;**<br>• **Annually, if BP >120-139/80-89 mm hg** | |
| **Vision** | • **Every 3 yrs up to age 40;**<br>• **Every 2 yrs aged 40+** | |
| **Abdominal Aortic Aneurysm** | **Once, between the age range of 65-75 and smoked 100+ cigarettes in lifetime** | |
| **Cholesterol Testing** | **Regularly beginning at age 20 with risk factors** | |
| **Diabetes Screening** | **With a sustained BP >/= 135/80 mm Hg** | |
| **Colorectal Cancer Screening** | • **Annually, Fecal Occult Blood Stool (FOBS);**<br>• **Every 5 yrs, Sigmoidoscopy with FOBS;**<br>• **Every 10 yrs, Colonoscopy** | |
| **Sexually Transmitted Diseases (STD's)** | **As necessary for those with risk factors** | |
| **Depression Screening** | **As necessary for those with risk factors** | |
| **Alcohol Misuse Screening** | **As necessary for those with risk factors** | |
| **Immunizations:**<br>**Pneumococcal (Pneumonia) Vaccine**<br>**Influenza (Flu) Vaccine** | • **Pneumonia: 1-2 doses up to age 64;**<br>• **Pneumonia: 1 dose age 65+**<br>• **Influenza: Annually** | |
| **Other** | | |

**Your major risk factors:**

**Family history of _____ Obesity_____ Diabetes_____**
**Hypertension_____ Fall Risk_____ Smoking Use_____ Other_____**

**Recommendations for improvement:**

**Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____**

**Referrals**

For Staff Use: *[list handouts, referrals, or other follow-up instructions here]*

## CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

| **Questions:** | **YES** | **NO** |
|---|---|---|
| 1. Have you ever felt that you ought to cut down on your drinking or drug use? | ☐ | ☐ |
| 2. Have people annoyed you by criticizing your drinking or drug use? | ☐ | ☐ |
| 3. Have you ever felt bad or guilty about your drinking or drug use? | ☐ | ☐ |
| 4. Have you ever had a drink or used drugs first thing in the morning **to steady your nerves or to get rid of a hangover?** | ☐ | ☐ |

**Scoring**
Regard one or more positive responses to the CAGE-AID as a positive screen.

**Psychometric Properties**

| The CAGE-AID exhibited: | **Sensitivity** | **Specificity** |
|---|---|---|
| One or more **Yes** responses | 0.79 | 0.77 |
| Two or more **Yes** responses | 0.70 | 0.85 |

(Brown 1995)

# Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *PHQ-9* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Feeling down, depressed, or hopeless. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Trouble falling or staying asleep, or sleeping too much. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Feeling tired or having little energy. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Poor appetite or overeating. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores): _____**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *GAD-7* | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Not being able to stop or control worrying. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Worrying too much about different things. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Trouble relaxing. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Being so restless that it's hard to sit still. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Becoming easily annoyed or irritable. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Feeling afraid as if something awful might happen. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores): _____**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

☐ ☐ ☐ ☐

UHS Rev 4/2020

# The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

**How Sleepy Are You?**

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

| Situation | Chance of Dozing |
|---|---|
| Sitting and reading | • |
| Watching TV | • |
| Sitting inactive in a public place (e.g., a theater or a meeting) | • |
| As a passenger in a car for an hour without a break | • |
| Lying down to rest in the afternoon when circumstances permit | • |
| Sitting and talking to someone | • |
| Sitting quietly after a lunch without alcohol | • |
| In a car, while stopped for a few minutes in traffic | • |

Total Score = _____

**Analyze Your Score**

**Interpretation:**

**0-7:** It is unlikely that you are abnormally sleepy.
**8-9:** You have an average amount of daytime sleepiness.
**10-15:** You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
**16-24:** You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

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**Appointment Date:** _____

# Social Needs Assessment Form

**Patient Name:** _____ **DOB:** _____

1. **What is your living situation today?**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live- I am temporarily staying with others, in a hotel, in a shelter,
   - ☐ outside on the street, one a beach, in a car, abandoned building, bus or train station
2. **In the past 12 months, have you:**
   - Had your utilities threatened to be shut off
     - ☐ No
     - ☐ Yes
     - ☐ Already shut off
   - Worried you would run out of food
     - ☐ Never true
     - ☐ Sometimes true
     - ☐ Often true
   - Has a lack of transportation kept you from a medical appointment, meeting, work, etc.
     - ☐ No
     - ☐ Yes
3. **In the past 2 weeks how often do you:** ***Please circle answers***
   - Feel lonely, or isolated from those around you
     - ☐ Never
     - ☐ Rarely
     - ☐ Sometimes
     - ☐ Often
     - ☐ Always
   - Have little interest or pleasure in doing things
     - ☐ Not at all
     - ☐ Several days
     - ☐ More than half the days
     - ☐ Nearly every day
   - Feel down depressed or hopeless
     - ☐ Not at all
     - ☐ Several days
     - ☐ More than half the days
     - ☐ Nearly every day

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# HIPAA Disclosure & Authorization Form 3

Name of Patient *(please print)* _____ Date _____

Signature _____ Date of birth _____

_____I do not want Crossroads Medical Associates ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____I authorize Provider to disclose information related to my care and treatment to the following individuals:

_____ _____

_____ _____

_____ _____

_____ _____

The authorization provided for above are subject to the following limitations and restrictions:

_____

_____

**TREATMENT AUTHORIZATION:**

I_____authorize medical treatment of myself or my minor child by physicians at Crossroads Medical Associates.

**NOTIFICATION AUTHORIZATION PLEASE COMPLETE BELOW:**

I authorize Crossroads' physicians and staff to contact me at the following number(s) for scheduling or to inform me of medical or laboratory test results:_____ _____ do not _____ authorize leaving the results of such tests at the number (e.g. on answering machine or voicemail). Additional instructions or restrictions:

_____

_____

# For the following form:

# MOLST

Please write your name, review with family if needed, and complete to the best of your ability.

If you would prefer to talk this form over with the doctor, print your name and bring the form with you.

# Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

| Patient's Last Name, First, Middle Initial | Date of Birth | ☐ Male ☐ Female |
|---|---|---|
| | | |

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

**CERTIFICATION FOR THE BASIS OF THESE ORDERS:** Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

**CPR (RESUSCITATION) STATUS:** EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

---

**No CPR, Option A, Comprehensive Efforts to Prevent Arrest:** Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

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_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

**SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)**

| Practitioner's Signature | Print Practitioner's Name | |
|---|---|---|
| | | |
| Maryland License # | Phone Number | Date |
| | | |

| Patient's Last Name, First, Middle Initial | Date of Birth | Page 2 of 2<br>☐ Male ☐ Female |
|---|---|---|

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

**2 ARTIFICIAL VENTILATION**

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

**3 BLOOD TRANSFUSION**

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

**4 HOSPITAL TRANSFER**

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

**5 MEDICAL WORKUP**

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

**6 ANTIBIOTICS**

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

**7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION**

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

**8 DIALYSIS**

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

**9 OTHER ORDERS** _____

_____

_____

_____

_____

**SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)**

| Practitioner's Signature | Print Practitioner's Name | |
|---|---|---|
| Maryland License # | Phone Number | Date |

## INSTRUCTIONS

**Completing the Form:** The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician, NP, or PA signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

**Selecting CPR (Resuscitation) Status:** EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

**No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option.** Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers.* Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

**No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR.** Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

**Location of Form:** The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

**Reviewing the Form:** These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians, NPs, or PAs shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

**Updating the Form:** The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form.

**Voiding the Form:** To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

**Revoking the Form's DNR Order:** In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

**Bracelets and Necklaces:** If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

**How to Obtain This Form:** Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician, NP, or PA sign, cut off strip, fold, and insert in bracelet or necklace.

☐ DNR A-1 Intubate ☐ DNR A-2 Do Not Intubate ☐ DNR B

Pt. Name _____ DOB _____

Practitioner Name _____ Date _____

Practitioner Signature _____ Phone _____