**MOLST QUALITY CHART REVIEW**

**MOLST QUALITY AUDIT TOOL: ACCURACY OF FORM COMPLETION**

We are collecting data to evaluate the accurate completion of the MOLST form throughout the community. To achieve a consistent evaluation process, we are requesting that this tool be used to audit completion of the MOLST forms. Thank you for your support.

Please return copies of completed audit forms to: Patricia Bomba M.D., 165 Court Street, Rochester, NY 14647.

**PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY**

<table>
<thead>
<tr>
<th>General</th>
<th>MOLST Form Present: □ No □ If present: □ Original Pink Form □ Photocopy □ Fax □ Other ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Facility type: □ Hospital □ Nursing Home □ Hospice □ PACE □ Assisted Living □ Enriched Housing □ Adult Home □ Physician Office</td>
</tr>
<tr>
<td></td>
<td>Location of form: □ Front of Chart □ Protective Sleeve □ MD Orders □ Special Section □ Other ______________________</td>
</tr>
<tr>
<td></td>
<td>Has the form been modified in any way? □ No □ If Yes: □ Bar Code □ Words Crossed Out □ Patient Identifier □ Logo □ Other ______________________</td>
</tr>
</tbody>
</table>

**MOLST SECTION**

**A** Resuscitation orders: □ DNR □ Full CPR □ No orders

**B** DNR (CPR) consent of patient: (Check all that apply)
- □ Patient/Resident Signature □ Verbal Consent □ Date □ Witness Signature
- □ HCA/Surrogate Signature (pt lacks capacity) □ Verbal Consent □ Date □ Witness Signature
- □ Supplemental Documentation Form is attached (patient lacks capacity)

**C** Physician signature for section A & B: (Check all that apply)
- □ Physician Signature □ Date □ Physician License# □ Physician Phone/Pager#

**D** Does the person have any Advance Directives?
- □ None □ Health Care Proxy □ Living Will □ Other written or oral advance directive
- □ If yes, is a copy in the chart? □ Yes □ No

**ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATIONS**

**E** Additional Treatment Guidelines:
- □ None Checked □ Limited Medical Interventions □ MD Signature & Dated
- □ Comfort Measures Only □ No Limitations

**Other orders or Instructions:** (Review each of the subsections and check if completed)
- □ None Checked □ Antibiotics □ MD Signature & Dated
- □ Additional Intubation and Ventilation Instructions
- □ Future Hospitalization/Transfer □ Other instructions
- □ Artificially Administered Fluids and Nutrition

□ Consent Signature & Dated

**F** Review of MOLST form
- Is the patient identifier on the MOLST Renew/Review section? □ Yes □ No
- Has the MOLST form ever been reviewed?
- □ Yes □ No □ N/A
- If yes, how many times?
- Appropriate physician signatures? □ Yes □ No

**ADDITIONAL COMMENTS**

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________________________________________________________________________

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