1. Please indicate which of the following applies to this patient:
   □ Deceased patient
   □ Adult patient discharged to:
     □ Home with home health care agency
     □ Hospice (home or inpatient)
     □ Nursing home/Assisted Living
     □ Skilled nursing/rehab

2. Was the patient 90 years or older at the time of chart review? □ No □ Yes

3. If 89 years or younger, enter the MONTH and YEAR the patient was born:
   MONTH: _____ YEAR: ______

4. Race/ethnicity as listed in medical record (check all that apply):
   □ Asian □ Black/African American □ Hispanic/Latino □ White
   □ Other □ Not available

5. What is patient’s primary form of health care insurance?
   □ Medicare □ Medicaid □ Other health insurance □ None/self-pay

6. What is the primary reason for this hospitalization? _______________________________

7. Indicate if the patient had any of the following medical conditions documented:
   □ Terminal illness □ End-stage condition □ Persistent vegetative state
   □ Decisional incapacity □ Don’t know
   What was basis for this determination? (check all that apply)
   □ Certification by 2 physicians □ Medical record documentation
   □ Other: (please indicate) _________________________________

8. a. Does the patient have an advance directive documented in the medical record?
   □ NO: There is no indication in the medical record that the patient has an advance directive
   □ YES: It is noted in the medical record that the patient has an advance directive, but there is no copy on file
   □ YES: There is a copy of an advance directive on file* If YES, what year was it done? ______
   *If available, please attach a copy of the living will treatment preferences portion of the advance directive, with identifiers redacted. [For Maryland’s living will document, this is pp. 5-7]
b. Was a durable power of attorney for health care ("health care agent") appointed?
   □ No       □ Yes       □ Don’t know/No advance directive on file

9. Was a 2-physician certification of medically ineffective treatment made for this patient?
   □ No       □ Yes       □ Don’t know       If YES, for what treatment(s)? ____________________________

10. Was a Do-Not-Attempt Resuscitation (DNAR/DNR) order documented during this hospital stay?
    □ No       □ Yes       □ Don’t know

11. Indicate if the patient was receiving any of the following treatments at the time of discharge (check all that apply):
    □ Mechanical ventilation       □ Kidney dialysis       □ Tube feedings       □ N/A (patient died)

12. a. Did the patient have a MOLST form* on hospital admission? □ No □ Yes □ Don’t know
    a. If YES, was this form voided after date of admission? □ No □ Yes □ Don’t know
    b. If a MOLST form presented on admission was voided, how soon after admission was it voided?
       □ N/A (patient died)
    *Please attach copies of ALL MOLST forms (written or voided during this hospital stay) with identifiers redacted.

13. Did the patient have a MOLST form on hospital discharge?
    □ No       □ Yes*       □ N/A (patient died)       □ Don’t know
    *If YES, please attach a copy of this MOLST form with identifiers redacted. Write “D/C” on top.

14. If the patient had a MOLST form on hospital discharge, did you find any documentation in the patient’s medical record summarizing the discussion informing the MOLST orders?
    □ No       □ Yes       □ Not applicable (no MOLST form completed at discharge or patient died)
    If YES, what was the discipline of the person discussing the MOLST form with the patient/
    surrogate? □ Medicine       □ Nursing       □ Social work       □ Chaplain
    □ Other: (indicate which) ____________________________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE:
MARYLAND MOLST NURSING HOME CHART REVIEW FORM

1. Is this chart REVIEW for a current or a deceased resident?
   □ Current
   □ Deceased

2. Is or was the resident 90 years or older at the time of chart review? □ No □ Yes

3. If 89 years or younger, enter the MONTH and YEAR the patient was born:
   MONTH: _____ YEAR: ______

4. Race/ethnicity as listed in medical record (check all that apply):
   □ Asian  □ Black/African American  □ Hispanic/Latino  □ White
   □ Other  □ Not available

5. Please indicate if the resident received any of the following forms of reimbursement after this most recent admission (check all that apply):
   □ Medicare Skilled Nursing Benefit
   □ Medicaid (no hospice benefit)
   □ Hospice Benefit (through Medicare or Medicaid)

6. Did the resident have any of the following medical conditions
   □ Terminal illness     □ End-stage condition     □ Persistent vegetative state
   □ Decisional incapacity □ Don’t know

   What was basis for this determination?
   □ Certification by 2 physicians  □ Medical record documentation
   □ Other: (please indicate) ______________________________________

7. a. Is there documentation that the resident has an advance directive?
   □ NO
   □ YES  If YES, what year was it done? ________

   If YES, is there a copy of the advance directive on file? □ No □ Yes*

   *If available, please attach a copy of the living will treatment preferences portion of the advance directive, with identifiers redacted. [For Maryland’s living will document, this is pp. 5-7]

   b. Is a durable power of attorney for health care (“health care agent”) appointed?
   □ No   □ Yes   □ Don’t know

8. Has a 2-physician certification of medically ineffective treatment been made for this resident?
   □ No   □ Yes   □ Don’t know     If YES, for what treatment(s)? __________________________

→ → → → PLEASE COMPLETE OTHER SIDE! → → → →
9. Indicate if the resident received any of the following treatments since the most recent admission to your facility: (check all that apply)
   □ Mechanical ventilation    □ Kidney dialysis    □ Tube feedings

10. Was the resident transferred from a hospital to your nursing home within the past year (include the initial admission to your facility if applicable)?
    □ No    □ Yes

11. How many VOIED MOLST forms* are present in the resident’s medical record? ______

   *Please attach copies of the CURRENT and ALL VOIED MOLST forms with identifiers redacted.

12. Is there any documentation in the resident’s medical record summarizing the discussion informing the current MOLST order form?
    □ No    □ Yes    □ Not applicable (No MOLST form)

    If YES, what was the discipline of the person discussing the MOLST form with the patient/surrogate? □ Medicine    □ Nursing    □ Social work    □ Chaplain
    □ Other: (indicate which) __________________________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE:
1. Is this chart REVIEW for a **current** or a **deceased** resident?
   - □ Current
   - □ Deceased

2. Is or was the resident **90 years or older** at the time of chart review? □ No □ Yes

3. If 89 years or younger, enter the MONTH and YEAR the patient was born:
   - MONTH: _____ YEAR: _____

4. Race/ethnicity as listed in medical record (check all that apply):
   - □ Asian
   - □ Black/African American
   - □ Hispanic/Latino
   - □ White
   - □ Other
   - □ Not available

5. What is patient’s primary form of health care insurance?
   - □ Medicare
   - □ Medicaid
   - □ Other health insurance
   - □ None/self-pay

6. a. Is there documentation that the resident has an advance directive?
   - □ NO
   - □ YES – If YES, what year was it done? ____________
     - If YES, is there a copy of the advance directive on file?* □ No □ Yes
     *If available, please attach a copy of the *living will treatment preferences* portion of the advance directive, with identifiers redacted. [For Maryland’s *living will document, this is pp. 5-7*]

   b. Is a durable power of attorney for health care (“health care agent”) appointed?
   - □ No □ Yes □ Don’t know

7. Has a 2-physician certification of decisional incapacity been made for this resident?
   - □ No □ Yes □ Don’t know

8. Has a 2-physician certification of medically ineffective treatment been made for this resident?
   - □ No □ Yes □ Don’t know
   - If YES, for what treatment(s)? ___________________________

9. Was the resident transferred from a hospital to your assisted living facility within the past year (include the initial admission to your facility if applicable)?
   - □ No □ Yes

10. How many VOIED MOLST forms* are present in the resident’s medical record? ______
    *Please attach copies of the CURRENT and ALL VOIED MOLST forms with identifiers redacted.
11. Is there any documentation in the resident’s medical record summarizing the discussion informing the current MOLST order form?

☐ No  ☐ Yes  ☐ Not applicable (no MOLST form)

If YES, what was the discipline of the person discussing the MOLST form with the patient/surrogate?

☐ Medicine  ☐ Nursing  ☐ Social work  ☐ Chaplain  ☐ Other: (indicate which) ___________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE:
MARYLAND MOLST HOME HEALTH AGENCY REVIEW FORM

1. Was the patient 90 years or older at the time of chart review? □ No □ Yes

2. If the patient was 89 years or younger at time of chart review, enter the MONTH and YEAR the patient was born: MONTH: _____ YEAR: ______

3. Race/ethnicity as listed in medical record (check all that apply):
   □ Asian   □ Black/African American   □ Hispanic/Latino   □ White
   □ Other   □ Not available

4. What is patient’s primary form of health care insurance?
   □ Medicare   □ Medicaid   □ Other health insurance   □ None/self-pay

5. a. Is there documentation that the patient has an advance directive?  
   □ NO  
   □ YES – If YES, what year was it done? ______
   If YES, is there a copy of the advance directive on file?* □ No □ Yes

   *If available, please attach a copy of the living will treatment preferences portion of the advance directive, with identifiers redacted. [For Maryland’s living will document, this is pp. 5-7]

   b. Is a durable power of attorney for health care (“health care agent”) appointed?
   □ No  □ Yes  □ Don’t know

6. Please check which of the following apply:
   □ Patient was referred to you from a hospital WITH a MOLST order from the hospital
   □ Patient was referred to you from a hospital WITHOUT a MOLST order from the hospital
   □ Patient was referred from another provider WITH a MOLST order from that provider
   □ Patient was referred from another provider WITHOUT a MOLST order from that provider

7. How many VOIDED MOLST forms* are present in the patient’s medical record? ______
   *Please attach copies of the CURRENT and ALL VOIDED MOLST forms with identifiers redacted.

8. Is there any documentation in the patient’s medical record summarizing the discussion informing the current MOLST order form? □ No □ Yes □ Not applicable (no MOLST form)
   If YES, what was the discipline of the person discussing the MOLST form with the patient/surrogate? □ Medicine □ Nursing □ Social work □ Chaplain
   □ Other: (indicate which) ________________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE or on the back of this form:
MARYLAND MOLST HOSPICE AGENCY REVIEW FORM

1. Was the patient 90 years or older at the time of chart review?  □ No  □ Yes

2. If the patient was 89 years or younger at time of chart review, enter the MONTH and YEAR the patient was born:  MONTH: _____ YEAR: _____

3. Race/ethnicity as listed in medical record (check all that apply):
   □ Asian  □ Black/African American  □ Caucasian  □ Latino/Hispanic  □ Not available  □ Other

4. What is/was patient’s primary form of health care insurance?
   □ Medicare    □ Medicaid      □ Other health insurance  □ None/self-pay

5. a. Is there documentation that the patient has/had an advance directive?
   □ NO
   □ YES
   If YES, is there a copy of the advance directive on file?*  □ No  □ Yes
   *If available, please attach a copy of the living will treatment preferences portion of the advance directive, with identifiers redacted. [For Maryland’s living will document, this is pp. 5-7]

   b. Was a durable power of attorney for health care (“health care agent”) appointed?
   □ No  □ Yes  □ Don’t know

6. Please check which of the following apply:
   □ Patient was referred to you from a hospital WITH a MOLST order from the hospital
   □ Patient was referred to you from a hospital WITHOUT a MOLST order from the hospital
   □ Patient was referred from another provider WITH a MOLST order from that provider
   □ Patient was referred from another provider WITHOUT a MOLST order from that provider

7. How many VOIDED MOLST forms* are present in the patient’s medical record? ______
   *Please attach copies of the CURRENT and ALL VOIDED MOLST forms with identifiers redacted.

8. Is there any documentation in the patient’s medical record summarizing the discussion informing the current MOLST order form?  □ No  □ Yes  □ Not applicable (no MOLST form)
   If YES, what was the discipline of the person discussing the MOLST form with the patient/surrogate?  □ Medicine  □ Nursing  □ Social work  □ Chaplaincy
   □ Other: (indicate which) ____________________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE or on the back of this form:

Questions? Contact atarzian@law.umaryland.edu – 443-794-4344
MARYLAND MOLST DIALYSIS CENTER REVIEW FORM

1. Was the patient 90 years or older at the time of chart review? □ No □ Yes

2. If the patient was 89 years or younger at time of chart review, enter the MONTH and YEAR the patient was born: MONTH: _____ YEAR: ______

3. Race/ethnicity as listed in medical record (check all that apply):
   □ Asian □ Black/African American □ Caucasian □ Latino/Hispanic
   □ Not available □ Other

4. What is patient’s form of health care insurance? (check all that apply)
   □ Medicare □ Medicaid □ Other health insurance □ None/self-pay

5. Indicate if the patient has any of following medical conditions:
   □ Terminal illness □ End-stage condition □ Persistent vegetative state
   □ Decisional incapacity □ Don’t know
   What was basis for this determination?
   □ Certification by 2 physicians □ Medical record documentation
   □ Other (please indicate) ________________________________

6. a. Is there documentation that the patient has an advance directive?
   □ NO: There is no indication in the medical record that the patient has an advance directive
   □ YES: It is noted in the medical record that the patient had an advance directive, but there is no copy on file
   □ YES: There is a copy of an advance directive on file* If YES, what year was it done? ______
   *If available, please attach a copy of the living will treatment preferences portion of the advance directive, with identifiers redacted. [For Maryland’s living will document, this is pp. 5-7]

   b. Was a durable power of attorney for health care (“health care agent”) appointed?
   □ No □ Yes □ Don’t know/No advance directive on file

7. Indicate if the patient receives either of the following:
   □ Mechanical ventilation □ Tube feedings

8. Where is this patient currently residing at (at time of this REVIEW)?
   □ Home □ Long term care □ Hospital □ Other: ________________

9. How many VOIDED MOLST forms* are present in the patient’s medical record? ______
   *Please attach copies of the CURRENT and ALL VOIDED MOLST forms with identifiers redacted.

→ → → → PLEASE COMPLETE OTHER SIDE! → → → →
10. Is there any documentation in the patient’s medical record summarizing the discussion informing the current MOLST order form?

□ No  □ Yes  □ Not applicable (no MOLST form)

If YES, what was the discipline of the person discussing the MOLST form with the patient/surrogate?

□ Medicine  □ Nursing  □ Social work  □ Chaplain  □ Other: (indicate which) ___________

Write any COMMENTS or CLARIFICATIONS about this chart REVIEW HERE:
MARYLAND MOLST EVALUATION PROJECT - DEMOGRAPHIC FORM FOR FACILITIES
PLEASE FILL THIS FORM OUT ONCE AND RETURN WITH YOUR FACILITY CHART REVIEWS

1. Please indicate the type of facility you are submitting these chart REVIEWS from:
   □ Hospital       □ Skilled nursing/rehab   □ Nursing home
   □ Assisted Living □ Home health agency    □ Hospice
   □ Kidney dialysis center

2. Please check all that apply to this facility:
   □ For-profit       □ Not-for-Profit       □ Teaching facility   □ Religiously affiliated

3. How many beds does this facility have? __________

4. Does this facility use an electronic medical record? □ No □ Yes □ Hybrid (electronic + paper)

5. Does this facility use the MOLST form as its resuscitation order form? □ No □ Yes

6. How has the facility trained professional clinical staff on MOLST? (check all that apply):
   □ External training seminar   □ Internal training seminar   □ Mandatory Curriculum
   □ Web/Online training        □ Self-paced educational materials □ Other: _______________

7. Please estimate what percentage of the facility’s professional clinical staff have been trained on MOLST: __________

8. How has the facility educated patients/families on MOLST? (check all that apply)
   □ Varies based on individual clinician □ Trained staff using a similar approach
   □ Informational packet               □ Promo WBAL video on Maryland MOLST website
   □ Other: (indicate what) _______________

9. Is there a MOLST “champion” or point person for this facility? □ NO □ YES □ DON’T KNOW
   If YES, what is that person’s job title or in what department does s/he work? ________________

10. On a scale of 1 to 5, if 1=Strongly Agree and 5=Strongly Disagree, indicate whether you agree or disagree with the following statements:
    a. The Maryland MOLST form has replaced advance directives at this facility. ______
    b. The Maryland MOLST form complements advance directives at this facility. ______
    c. The Maryland MOLST form is improving end-of-life care at this facility. ______

11. Who completed the chart REVIEWS from this facility? (check all that apply)
    □ Nurse              □ Social worker    □ Medical records staff
    □ Volunteer          □ Research Assistant □ Quality Improvement/Admin staff
    □ Other: _______________

12. If you are willing to share your contact information, please complete the following:
    YOUR NAME: ___________________________ E-MAIL: ___________________________
    JOB TITLE: ___________________________ PHONE #: ___________________________

Questions? Contact atarzian@law.umaryland.edu – 443-794-4344