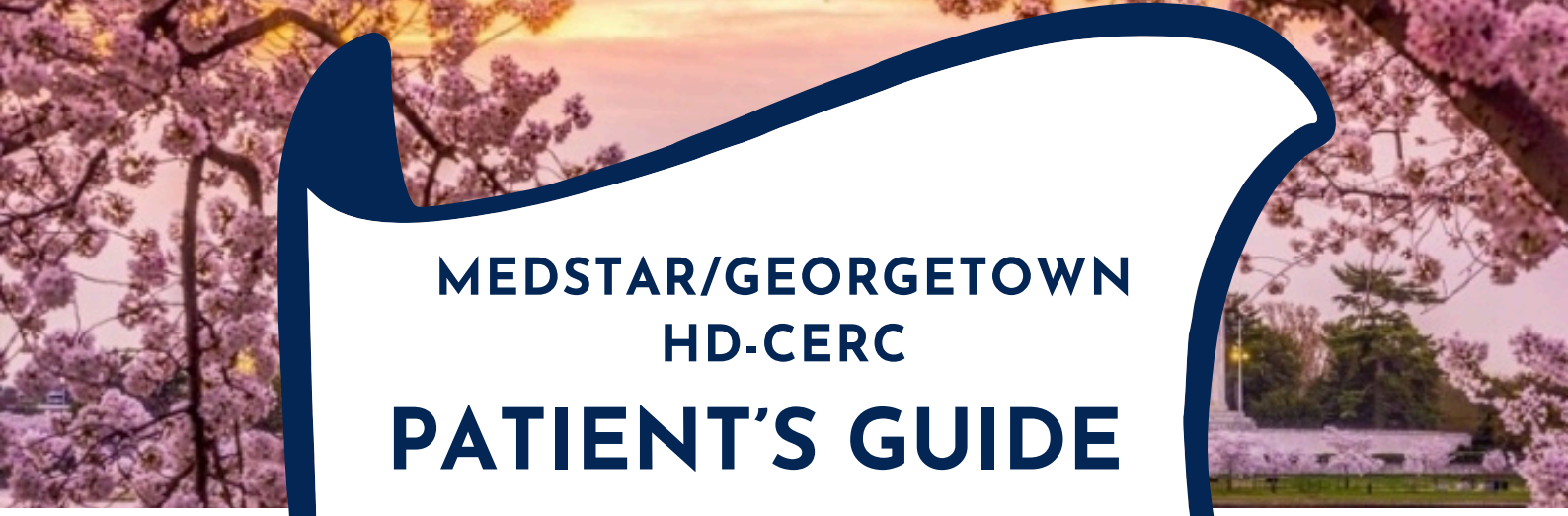


MEDSTAR/GEORGETOWN HD-CERC

PATIENT'S GUIDE TO CARE

WELCOME TO THE MEDSTAR GEORGETOWN HUNTINGTON DISEASE CARE, EDUCATION, AND RESEARCH CENTER (HD-CERC)!

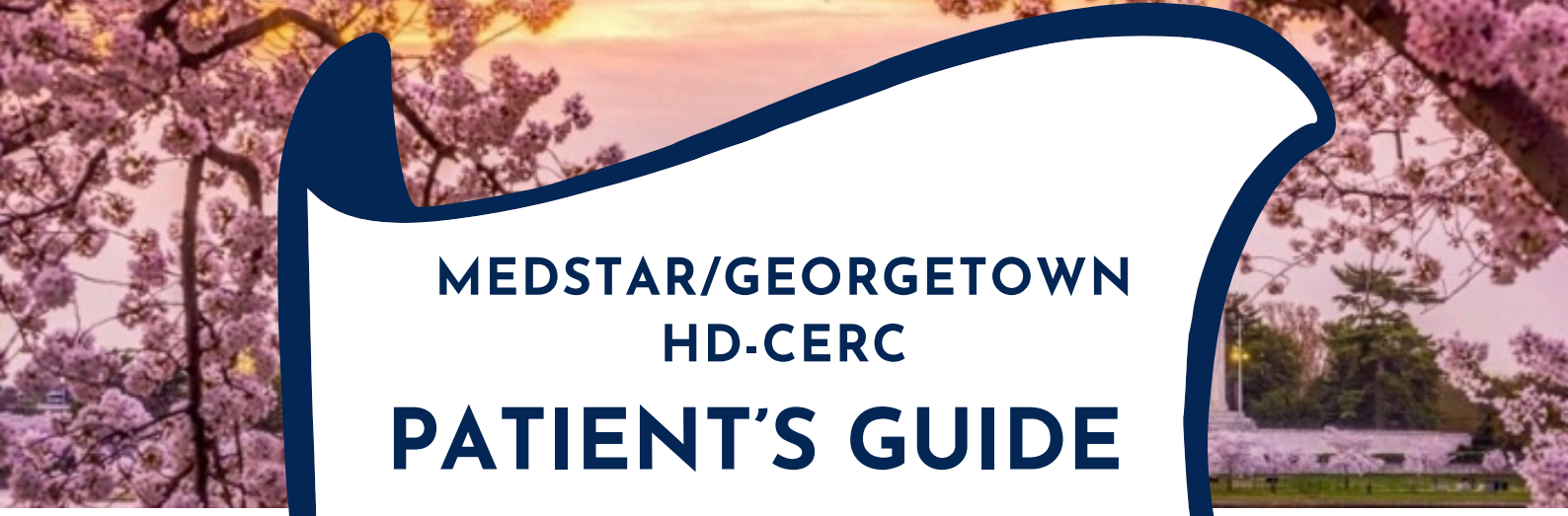
WE ARE COMMITTED TO PROVIDING COMPREHENSIVE AND COMPASSIONATE CARE FOR INDIVIDUALS AND FAMILIES IMPACTED BY HUNTINGTON'S DISEASE (HD). OUR MULTIDISCIPLINARY TEAM IS HERE TO SUPPORT YOU THROUGH EVERY STAGE OF YOUR JOURNEY, OFFERING EXPERT CLINICAL CARE, TAILORED EDUCATION, AND OPPORTUNITIES TO PARTICIPATE IN GROUNDBREAKING RESEARCH. THIS GUIDE IS DESIGNED TO HELP YOU NAVIGATE AVAILABLE RESOURCES, UNDERSTAND YOUR CARE OPTIONS, AND FEEL EMPOWERED TO MAKE INFORMED DECISIONS ABOUT YOUR HEALTH AND WELL-BEING.

FOR MORE INFORMATION VISIT
HTTPS://NEUROLOGY.GEORGETOWN.EDU/HDCERC/

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health



MEDSTAR/GEORGETOWN
HD-CERC

PATIENT'S GUIDE TO CARE

Table of Contents:

GEORGETOWN UNIVERSITY
Georgetown University Medical Center

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

HD-CERC CONTACT INFORMATION

FOR CLINIC APPOINTMENTS:

MARA MCCARTIN
202-687-2451
MARA.MCCARTIN@MEDSTAR.NET

FOR SOCIAL WORK QUESTIONS:

EMILY WEAVER
202-687-1366
EMILY.A.WEAVER@MEDSTAR.NET

FOR RESEARCH QUESTIONS

ROBIN KUPREWICZ
202-893-1115
RK1028@GEORGETOWN.EDU

IF YOU ARE IN CRISIS PLEASE CALL 911, THE NATIONAL SUICIDE HOTLINE AT 988/988LIFELINE.ORG, OR GO TO YOUR LOCAL EMERGENCY ROOM

GEORGETOWN UNIVERSITY
Georgetown University Medical Center

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

HD-CERC CLINIC DIRECTIONS

1. GEORGETOWN UNIVERSITY HOSPITAL (3800 RESERVOIR RD NW, WASHINGTON, DC 20007):
EVERY FIRST THURSDAY OF THE MONTH
PHONE: 855-546-0576

PATIENTS AND VISITORS MUST ENTER THE HOSPITAL CAMPUS AT ENTRANCE 2 OFF RESERVOIR ROAD. AFTER DRIVING IN ENTRANCE 2, FOLLOW THE ROAD TOWARD THE EMERGENCY DEPARTMENT AND DRIVE AROUND THE CIRCLE TO ACCESS THE PATIENT AND VISITOR PARKING GARAGE. MEMBERS OF OUR STAFF WILL BE ON-SITE TO DIRECT YOU INTO THE GARAGE. WHEN YOU ENTER THE GARAGE, THERE IS VALET AND SELF-PARKING. PARKING VALIDATION IS AVAILABLE AT THE FRONT DESK OF THE HOSPITAL. PARKING IS AVAILABLE AT A REDUCED RATE WITH VALIDATION.

FOR CLINIC:
CLINIC VISITS TAKE PLACE AT THE NEUROLOGY DEPARTMENT AT MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL. THE NEUROLOGY DEPARTMENT IS LOCATED ON THE 7TH FLOOR IN PHC (PASQUERILLA HEALTHCARE CENTER). UPON ENTERING THE HOSPITAL, FIRST FOLLOW SIGNS TO PHC BUILDING. ONCE AT THE PHC BUILDING, TAKE ELEVATORS UP TO 7TH FLOOR. PLEASE CHECK IN FOR YOUR APPOINTMENT AT THE FRONT DESK OF NEUROLOGY.

GEORGETOWN UNIVERSITY
Georgetown University Medical Center

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

HD-CERC CLINIC DIRECTIONS

2. MEDSTAR GEORGETOWN NEUROLOGY AT MCLEAN (1420 BEVERLY RD, SUITE 300, MCLEAN VA 22101): EVERY 2ND WEDNESDAY OF THE MONTH PHONE: 202-295-0540

UPON ARRIVING AT THE FACILITY, PARKING AVAILABLE FOR FREE FOR PATIENTS UNDER THE BUILDING. ENTER BUILDING AND TAKE ELEVATOR TO FLOOR 3. FOLLOW SIGNS FOR SUITE 300 AND CHECK IN FOR YOUR APPOINTMENT AT THE FRONT DESK OF SUITE.

3. MEDSTAR MONTGOMERY MEDICAL CENTER (18111 PRINCE PHILIP DRIVE, SUITE 101, OLNEY, MD 20832): EVERY FOURTH FRIDAY OF THE MONTH PHONE: 301-774-8956

UPON ARRIVING AT THE FACILITY, FOLLOW SIGNS TO BUILDING 18111. PARKING IS AVAILABLE FOR FREE OUTSIDE OF THE BUILDING. WHEN YOU ENTER THE BUILDING, YOU WILL SEE SUITE 101 ON THE GROUND FLOOR, ENTER THE SUITE AND CHECK IN FOR YOUR APPOINTMENT AT THE FRONT DESK.

HD-CERC SUPPORT GROUPS

1. CAREGIVER CHECK-IN CALL:

THIS IS A CLOSED GROUP FOR CAREGIVERS OF INDIVIDUALS WITH HUNTINGTON'S DISEASE TO HAVE AN OPPORTUNITY TO SHARE, CONNECT, AND LEARN FROM ONE ANOTHER. PLEASE FILL OUT THIS FORM IF YOU ARE INTERESTED IN JOINING THIS GROUP.

TO JOIN PLEASE FILL OUT GOOGLE FORM

2. YOUNG ADULT MESSAGING GROUP:

THIS IS A CLOSED GROUP FOR YOUNG ADULTS IMPACTED BY HD (I.E. AT-RISK, RECENTLY TESTED, COMES FROM AN HD FAMILY, PARTNER OF AN INDIVIDUAL WITH HD, ETC). ALSO THE GROUP HAS AN ONLINE MESSAGING GROUP ON THE APP SIGNAL, WHERE YOU CAN CONNECT WITH ONE ANOTHER. THIS GROUP WILL BE MONITORED BY HD-CERC TEAM MEMBERS, BUT SERVES AS A SPACE FOR MEMBERS TO INTERACT WITH ONE ANOTHER, ASK QUESTIONS, AND RESPOND TO WEEKLY QUESTIONS POSED BY HD-CERC TEAM MEMBERS.

TO JOIN PLEASE FILL OUT GOOGLE FORM

3. VIRTUAL EDUCATIONAL SUPPORT GROUP:

OPEN TO ANYONE IN THE HD COMMUNITY

FOR SUPPORT GROUP DATES AND ZOOM LINKS - JOIN OUR EMAIL LIST

GEORGETOWN UNIVERSITY
Georgetown University Medical Center

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

EMERGENCY CONTACT INFORMATION

PRIMARY

NAME:

RELATIONSHIP:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

SECONDARY

NAME:

RELATIONSHIP:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

MY MEDICAL TEAM

HD PSYCHIATRIST

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

FOR RX REFILLS:

HD NEUROLOGIST

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

FOR RX REFILLS:

PRIMARY CARE

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

OTHER MEDICAL CONTACT

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

MY MEDICATION LIST

DOCTOR'S NAME:
DOCTOR'S PHONE NUMBER:

WHEN DO I TAKE?	MEDICATION NAME	DOSAGE	HOW TO TAKE MEDICATION
MORNING			
NOON			
EVENING			
BEDTIME			
ONLY TAKE WHEN NEEDED			

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

PRESCRIPTION
REFILL GUIDE

PRESCRIPTION REFILL GUIDE

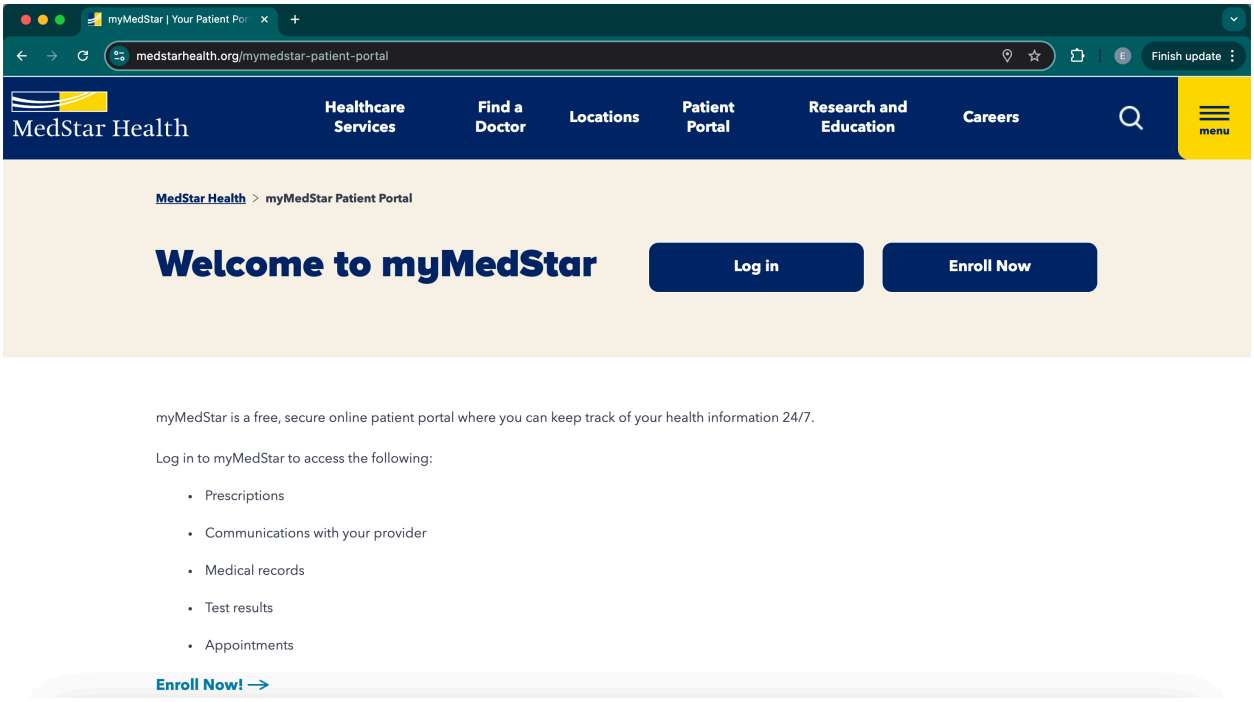
GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

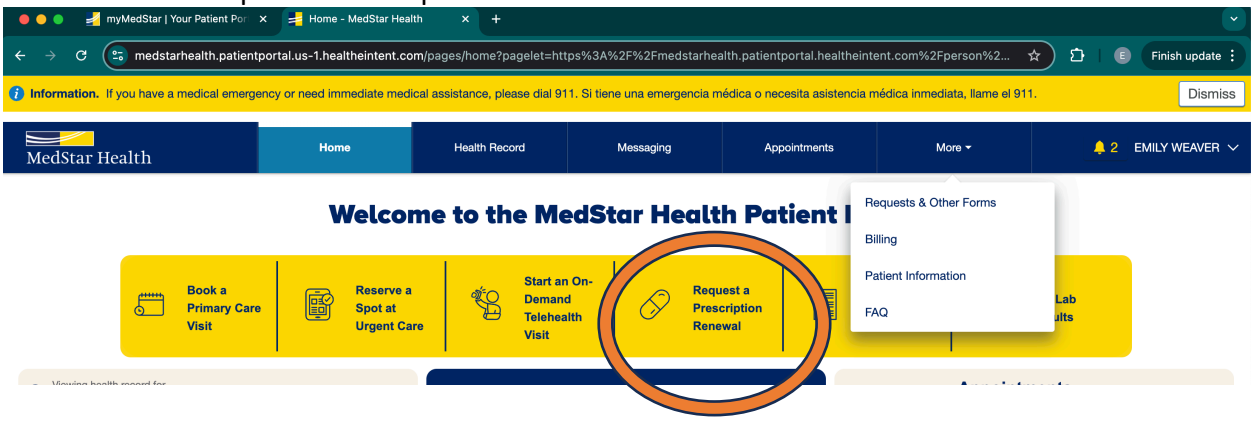
MedStar Health

How to refill a prescription online

1. Login to/or Create your MedStar Patient Portal at https://www.medstarhealth.org/mymedstar-patient-portal



2. Select “Request a Prescription Renewal.”



3. Select to whom would like to send the renewal request (i.e. Dr. Karen Anderson, Dr. Fahd Amjad, Dr. Steven Lo, etc.). Select which prescriptions you would like to renew.

MEDICAL
RECORDS
REQUEST GUIDE

MEDICAL RECORDS REQUEST GUIDE

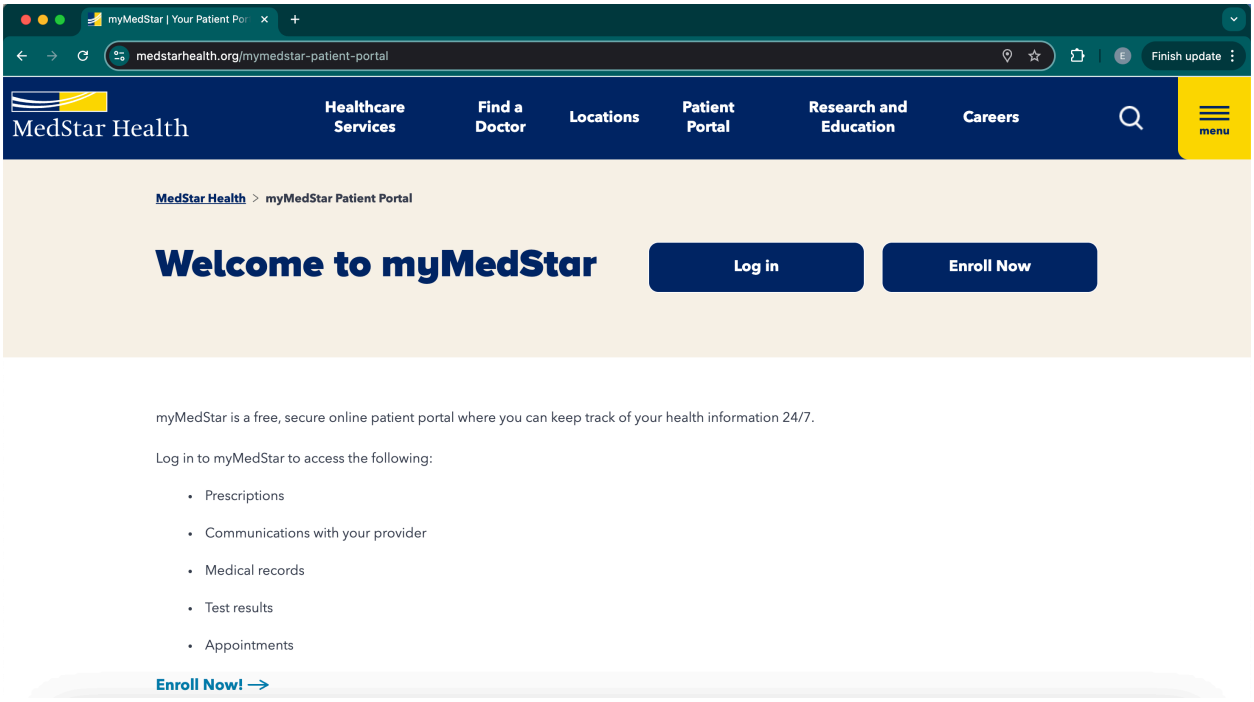
GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

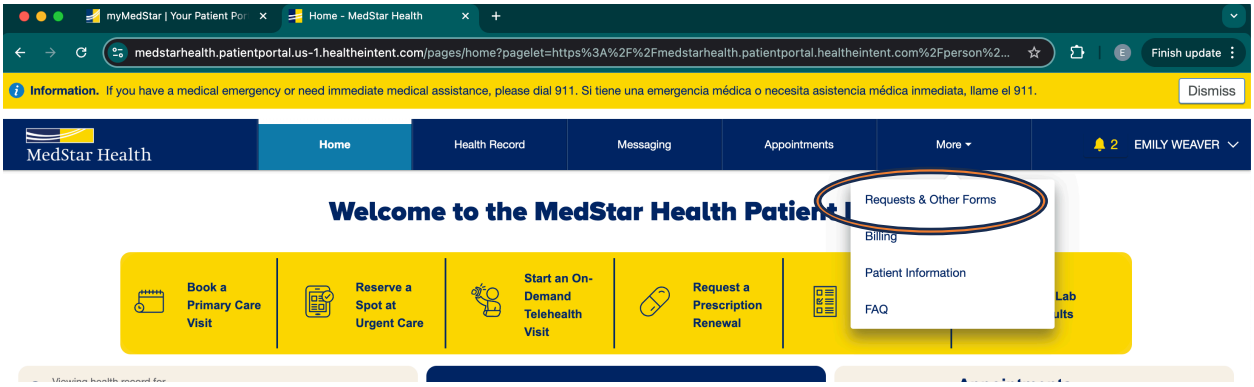
MedStar Health

How to request you Medical Records online:

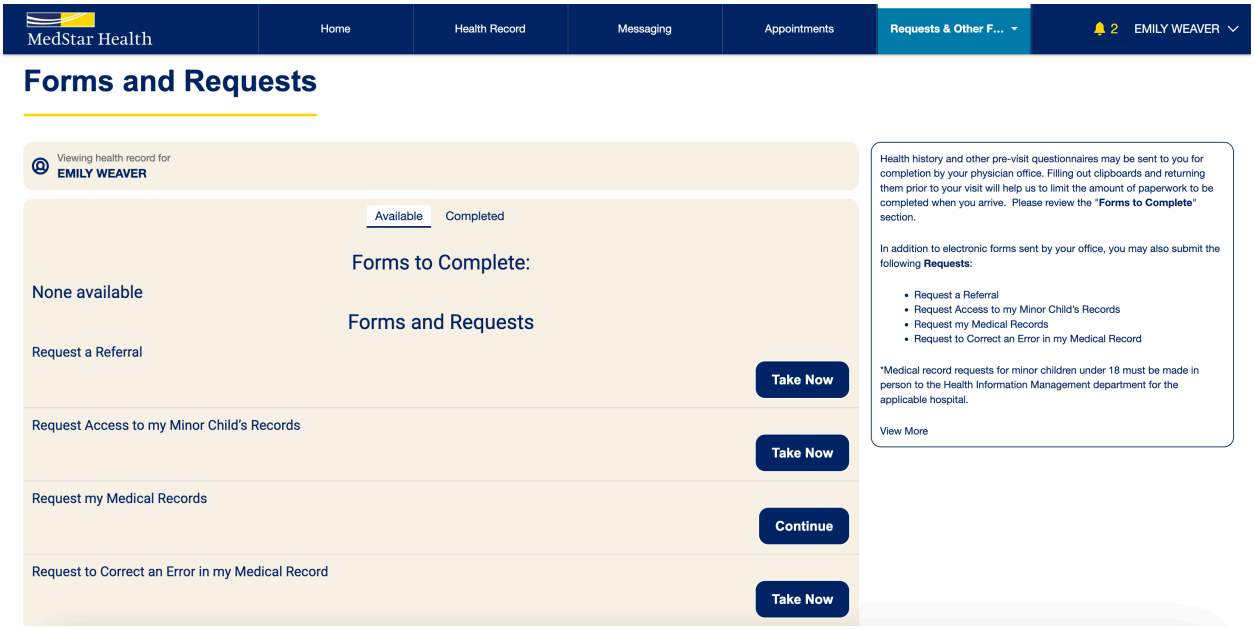
1. Login to/or Create your MedStar Patient Portal at https://www.medstarhealth.org/mymedstar-patient-portal



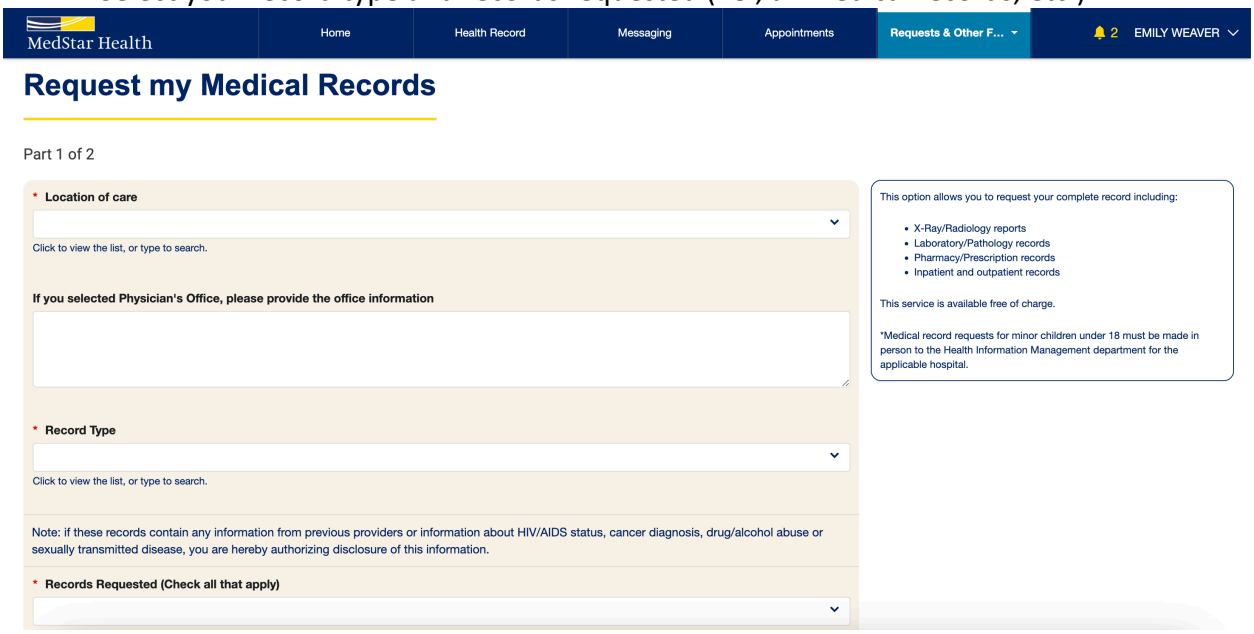
2. Go to the 'MORE' tab on the right of the screen and click on "Requests and Other Forms."



3. Select the third option down “Request my Medical Records.” Click “Continue.”



4. Select the location where you received care (i.e., MedStar Georgetown University Hospital, MedStar Neurology at McLean, MedStar Montgomery Medical Center, etc.) Select your record type and records requested (i.e., all medical records, etc.).



LONG TERM CARE FACILITIES IN DC, MD, VA

MARYLAND

Somerford House & Place Frederick
2100 Whittier Drive
Frederick, MD 21702
301-668-3930

Brookdale Senior Living Olney
2611 Olney Sandy Spring Road
Olney, MD 20832
240-991-5260

Arbor Terrace Fulton
11584 Scaggsville Road
Fulton, MD 20759
301-888-6192

VIRGINIA

Arbor Terrace Prince William Commons
14080 Central Loop
Woodbridge, VA 22193
571-470-6859

The Kensington Reston
11501 Sunrise Valley Drive
Reston, VA 20191
571-494-8100

***NOT A COMPREHENSIVE LIST
These are not HD Specialty Units, but facilities we have worked with in the past

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

ACTIONABLE STEPS ACROSS THE DISEASE STAGE

EARLY STAGE

- GET CONNECTED WITH YOUR CENTER OF EXCELLENCE
- ADVANCED DIRECTIVES
- MEDICAL POWER OF ATTORNEY (POA)
- FINANCIAL POWER OF ATTORNEY
- LIVING WILL
- CREATE A MEDSTAR PATIENT PORTAL ACCOUNT
- EXPLORE BRAIN/BODY DONATION
- DISCUSS PLANS/WISHES FOR END OF LIFE
- CONSIDER ENGAGING IN RESEARCH

MID-STAGE

- TOUR ASSISTED LIVING AND/OR NURSING FACILITIES
- CONTINUE TO DISCUSS PLANS/WISHES FOR END OF LIFE
- ENGAGE SUPPORT/HELP AT HOME
- CREATE A MEDICATION CALENDAR OR LIST
- SCHEDULE APPOINTMENTS WITH YOUR CARE TEAM

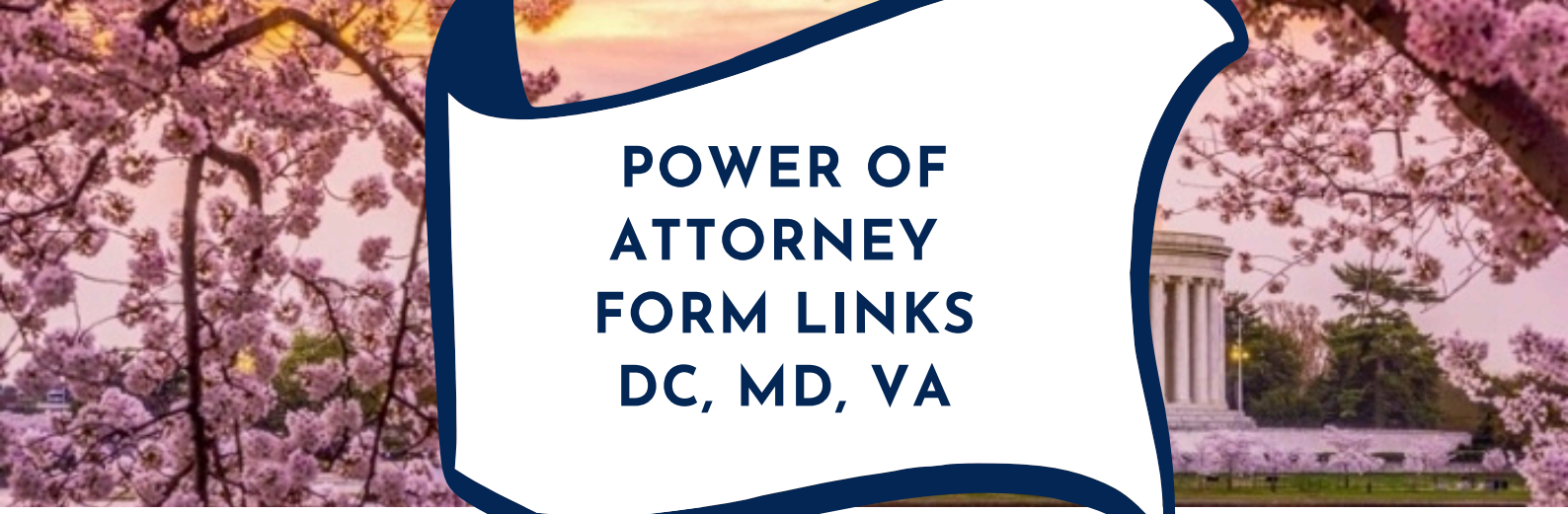
LATE STAGE

- CONNECT HD-CERC TEAM TO YOUR OTHER CARE PROVIDERS
- ESTABLISH SPIRITUAL, MENTAL, EMOTIONAL SUPPORTS FOR YOURSELF AND FAMILY MEMBERS
- THINK ABOUT THINGS YOU'D LIKE TO BRING TO LONG TERM CARE WITH YOU (BOOKS, PHOTOS, ETC.)

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health



POWER OF ATTORNEY FORM LINKS DC, MD, VA

MARYLAND

WASHINGTON, DC

VIRGINIA

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

ADVANCE DIRECTIVE

Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

This document has been prepared and distributed as an informational service of the District of Columbia Hospital Association.

INSTRUCTIONS AND DEFINITIONS

Introduction:
This form is a combined durable power of attorney for health care and living will for use in D.C., Maryland and Virginia. With this form, you can:

- Appoint someone to make medical decisions for you if you, in the future, are unable to make those decisions for yourself.
- Indicate what medical treatment you do or do not want if, in the future, you are unable to make your wishes known.

Directions:

- Read each section carefully.
- Talk to the person you plan to appoint to make sure that he/she understands your wishes and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want under parts 1, 2 and 3. Your advance directive should be valid for whatever part(s) you fill in as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate piece of paper but you should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give to your family and anyone else who might be involved in your care a copy of your advance directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

WORDS YOU NEED TO KNOW

Advance Directive: A written document that tells what a person wants or does not want if he/she in the future can't make his/her wishes known about medical treatment.
Artificial Nutrition and Hydration: When food and water are fed to a person through a tube.
Autopsy: An examination done on a dead body to find the cause of death.
Comfort Care: Care that helps to keep a person comfortable but does not make him/her better. Bathing, turning, and keeping a person's lips moist are types of comfort care.
CPR (Cardiopulmonary Resuscitation): Treatment to try to restart a persons breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatment.
Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his or her own medical decisions.
Life-Sustaining Treatment: Any medical treatment that is used to keep a person from dying. A breathing machine, CPR and artificial nutrition and hydration are examples of life-sustaining treatments.
Living Will: An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make hi/her wishes known.
Organ and Tissue Donation: When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.
Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong a person's dying if the person is suffering from a terminal condition.

D.C., Maryland and Virginia

ADVANCE DIRECTIVE
Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, _____ write this document as a directive regarding my medical care.

Put the initials of your name by the choices you want.

PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

_____I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

NAME_____PHONE: HOME _____WORK_____

ADDRESS_____

_____

If the person above can't or will not make decisions for me, I appoint this person:

NAME_____PHONE :HOME_____WORK_____

ADDRESS_____

_____

_____I have not appointed anyone to make health care decisions for me in this or any other document.

I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below:

PART 2. MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition:
Life-Sustaining Treatments

_____ I do not want life-sustaining treatments (including CPR) started. If life-

sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments that my doctors think are best for me.
_____ Other wishes: _____

Artificial Nutrition and Hydration
_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is strated, I want it stopped.
_____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.
_____ Other wishes: _____

Comfort Care
_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
_____ Other wishes: _____

B. These are my wishes if I am ever in a persistent vegetative state:
Life-Sustaining Treatments
_____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments that my doctors think are best for me.
_____ Other wishes:_____

Artificial Nutrition and Hydration
_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
_____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.
_____ Other wishes:_____

Comfort Care
_____ I want to be kept as comfortable and free of pain as possible even if such care prolongs my dying or shortens my life.
_____ Other wishes: _____

C. Other Directions
You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document please indicate them here:

_____
_____

PART 3. OTHER WISHES
A. Organ Donation

_____ I do not wish to donate any of my organs or tissues.
_____ I want to donate all of my organs and tissues.
_____ I only want to donate these organs and tissues:_____
_____ Other wishes:_____

Autopsy

_____ I do not want any autopsy.
_____ I agree to an autopsy if my doctors wish it.
_____ Other wishes:_____

If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put here the number of pages you are adding:____

PART 4. SIGNATURE

You and two witnesses must sign this document for it to be legal.

A. Your Signature

By my signature below I show that I understand the purpose and the effect of this document.

NAME_____DATE_____

ADDRESS_____

B. Your Witnesses' Signature

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of health care provider who is now, or ahs been in the past, responsible for the care of the person making this advance directive.

Witness#1

NAME_____DATE_____

ADDRES_____

Witness#2

NAME_____DATE_____

ADDRESS_____

RESUSCITATION ORDERS FORM LINKS
DC, MD, VA

MARYLAND

WASHINGTON, DC

VIRGINIA

GEORGETOWN UNIVERSITY
Georgetown University Medical Center

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HIPAA PERMITS DISCLOSURE OF THIS DOCUMENT TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

DC Medical Orders for Scope of Treatment (MOST)

Patient Last Name / First Name / Middle Initial

Address

City/State/Zip Code

Medical Conditions/Patient Goals:

_____/_____/_____ Date of Birth (MM/DD/YYYY)

_____ _____ _____ _____ Last 4 Digits of SSN (optional)

☐ Male ☐ Female ☐ Transgender ☐ Other

Instructions for Responding Providers:

FIRST follow these orders, **THEN** contact physician or nurse practitioner. The MOST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a MOST form is always voluntary. Everyone shall be treated with dignity and respect. **PLEASE email completed form as a PDF document to DC.MOST@dc.gov or fax to 202-671-0707. To print the DC MOST form, go to: dchealth.dc.gov/most**

A Cardio-Pulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

Check One

When not in cardiopulmonary arrest, go to part B.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation (DNAR) / Allow Natural Death (AND)**
Choosing **DNAR** will include appropriate comfort measures.

B Medical Interventions: Person has pulse and/or is breathing.

Check One

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures**. Includes care described below. Use medical treatment, IV fluids and cardiac care as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer**: EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional Orders: *(e.g. dialysis)* _____

C Medical Treatment Preferences:

Check One

Medically-assisted Nutrition:
(Always offer food and liquids by mouth if feasible.)

☐ Trial period of medically-assisted nutrition by tube.
(Goal:_____)

☐ No medically-assisted nutrition by tube.

☐ Long-term medically-assisted nutrition by tube.

Antibiotics:

☐ Use antibiotics for prolongation of life.

☐ Do not use antibiotics except when needed for symptom management

Additional orders: *(e.g. dialysis, blood products, implanted cardiac devices. Attach additional orders if necessary.)*

DC HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

D **Signatures:** The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by an authorized representative, the patient must be mentally incapacitated and the person signing is the legal authorized representative.

Discussed with:	PRINT — MD/DO/APRN Name ***(required)***	Phone Number
☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Domestic Partner ☐ Health Care Agent (Durable Power of Attorney for Healthcare) ☐ Adult child of patient	X MD/DO/APRN Signature ***(required)***	Date ***(required)***
	MD/DO/APRN License Number ***(required)***	
PRINT — Patient or Legal Authorized Representative Name		Phone Number
X Patient or Legal Authorized Representative Signature ***(required)***		Date ***(required)***

Person has: ☐ Health Care Directive (Living Will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany MOST

KEEP ORIGINAL DC MOST FORM WITH PATIENT'S MEDICAL RECORDS

Health Care Professional Information:

NOTE: A person with capacity may always consent to or refuse medical care interventions, regardless of information represented on any document, including this one.

Completing MOST

- Completing a MOST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their authorized representative and medical provider based on the person's preferences and medical condition.
- MOST must be signed by a MD/DO/APRN and patient, or their authorized representative, to be valid. Verbal orders are acceptable with follow-up signature by a MD/DO/APRN in accordance with facility/community policy.

Using MOST

- Any incomplete section of MOST implies full treatment for that section.
- This MOST is valid in all care settings including hospitals until replaced by new physician orders.
- The MOST is a set of medical orders.
- The MOST does not replace an advanced directive.
- An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name an authorized representative decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A, B and C:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation"
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment".
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment".
- Oral fluids and nutrition must always be offered if medically feasible.

SECTION D:

- Patient/Authorized Representative and MD/DO/APRN signatures.

Reviewing MOST

This MOST should be reviewed periodically whenever:

1. The person is transferred from one care setting or care level to another,
   or
2. There is a substantial change in the person's health status,
   or
3. The person's treatment preferences change.

To void this form, draw a line through "Medical Orders" and write "VOID" in large letters. Any changes require a new MOST.

Review of this MOST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

Version 4.29.19

Photocopies and faxes of signed MOST forms are legal and valid. May make copies for records.

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.

_____ **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 ☐ 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 _____

Virginia
POLST
Portable Medical Orders
A Participating Program of the National POLST Collaborative

*** National POLST Form NOTICE ***

The National POLST form is now approved for use in Virginia. While the Virginia POST form may still be used, transitioning to the National POLST form is recommended.

The National POLST Form is a portable medical order set. Health care professionals should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

This form should be obtained from and completed with a health care professional. **It should not be provided to patients or individuals to complete.**

Virginia and the National POLST Form

- POLST is not valid until signed by a physician, nurse practitioner or physician assistant who has a bona fide relationship with the patient. See Code of Virginia §54.1-2957.02 and §54.1-2952.2 respectively for further information.
- Use of the original form is encouraged. A photocopy, fax, or electronic version should be honored as if it were an original.
- Other DNR forms continue to be recognized under Administrative Code of Virginia §12VAC5-66-10. Such forms include, but are not limited to the Virginia DDNR form/POST/MOST/POLST/MOLST/ Approved DNR jewelry
- If "No CPR: Do Not Attempt Resuscitation" is checked in Section A, and patient has signed the form, no one has the authority to revoke consent for the DDNR order other than the patient as stated in the Code of Virginia §54.1-2987.1.
- If "Yes CPR: Attempt Resuscitation" is checked in Section A, a legally authorized decision maker may make changes to carry out the patient's preferences in light of the patient's changing condition.

Printing the National POLST Form

- **Do not alter this form.**
- Print BOTH pages as a double-sided form on a single sheet of paper.
- Printing on bright yellow paper is recommended by EMS and the Virginia POLST Collaborative but printing on white paper is acceptable.
  Paper suggestion: 8.5 x 11, 23.36 M weight (cardstock), Lift-Off Lemon by Astrobrights

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | **Authority:**

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/___ | **Phone # :**

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: Night:
Primary Care Provider Name:		Phone:
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone:	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed (mm/dd/yyyy):_____/_____/_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #:

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info www.virginiapolst.org	For Barcodes / ID Sticker

HANDICAP PARKING PLACARD DC, MD, VA

MARYLAND

WASHINGTON, DC

VIRGINIA

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789

Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University

MedStar Health

Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001
www.dmv.virginia.gov

DISABLED PARKING PLACARD OR LICENSE PLATES APPLICATION

Purpose: Persons with disabilities use this form to apply for a disabled parking placard or disabled parking license plates.

Instructions: **For a disabled parking placard or replacement placard ID car**d, complete only this application. No fees apply. Your disabled parking placard or replacement placard ID card will be mailed to you. Only one placard may be issued to you.

For disabled parking license plates, complete this application and the **VSA 10** application. Fees apply based on the selected license plates. Disabled parking license plates may be available at a Customer Service Center, a DMV Select office or may be mailed to you. You may request disabled parking license plates for any vehicles you own. **Note:** Only permanently disabled persons or institutions that transport individuals with disabilities may obtain disabled license plates.

Submit all required applications and fees to any Customer Service Center, DMV Select, or by mail to: DMV, Data Integrity, P.O. Box 85815, Richmond, VA 23285-5815.

APPLICANT INFORMATION (person with disability)

FULL LEGAL NAME (last) (first) (middle) (suffix)	DMV ASSIGNED NUMBER OR SOCIAL SECURITY NUMBER

NOTE: If you enter a residence or mailing address that is other than what is currently on DMV's system, complete an "Address Change Request" (ISD 01).

CURRENT RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

CITY OR COUNTY OF RESIDENCE	DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER
	( )

MAILING ADDRESS (if different from above)	CITY	STATE	ZIP CODE

BIRTH DATE (mm/dd/yyyy)	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT
			FT IN	LBS

APPLICATION TYPE (select one)

ORIGINAL APPLICATION:

- ☐ DISABLED PARKING PLACARD — No fee required *(includes ID Card)*
- ☐ DISABLED PARKING LICENSE PLATE — (complete form VSA 10)

RENEWAL APPLICATION:

- ☐ RENEW PERMANENT DISABLED PARKING PLACARD — No fee required

APPLICATION FOR REPLACEMENT/REISSUE:

- ☐ DISABLED PARKING PLACARD — No fee required *(includes ID Card)*
- ☐ DISABLED PLACARD ID CARD ONLY — No fee required
- ☐ DISABLED LICENSE PLATE — ($10.00 fee)

REASON FOR REPLACEMENT/REISSUE:

- ☐ Lost
- ☐ Destroyed/Mutilated
- ☐ Stolen
- ☐ Never Received

DISABLED PARKING LICENSE PLATES (HP) (check one, if applicable)

- ☐ The vehicle on which HP plates will be used is specifically equipped and used for transporting groups of physically disabled persons.
- ☐ I am the vehicle owner and the parent/legal guardian of a disabled dependent(s). List the name of each disabled person below.

_____

APPLICANT CERTIFICATION (person with disability/parent/legal guardian)

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000.00 and up to 6 months in jail and/or revocation of disabled parking privileges. I certify that I have a (check one): ☐ Temporary ☐ Permanent disability that limits or impairs my ability to walk or creates a safety concern while walking.

I also understand that the disabled parking placard or plates issued to me cannot be loaned to anyone, including family members or friends, to benefit a person other than myself.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

APPLICANT/PARENT/LEGAL GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)

DMV USE ONLY

TEMPORARY PLACARD (up to 12 months) ☐ ORIGINAL (Medical professional certification required.) ☐ REPLACEMENT/REISSUE	**HP PLATES** ☐ ORIGINAL PLATES ☐ REPLACEMENT/REISSUE	15-DAY PLACARD RECEIPT NUMBER
PERMANENT PLACARD (5 years) ☐ ORIGINAL (Medical professional certification required.) ☐ REPLACEMENT/REISSUE ☐ RENEWAL (No medical professional certification required)	PLACARD EXPIRATION DATE (mm/dd/yyyy)	EMPLOYEE STAMP

The front of this form must be completed before the medical professional signs the certification.

APPLICANT FULL LEGAL NAME (last, first, middle, suffix)

NOTE: (This page does not have to be completed to renew permanent placards.)

DISABILITY TYPE

☐ **Temporarily limited or impaired** beginning date (mm/dd/yyyy) _____ and ending date (mm/dd/yyyy) _____ (not to exceed 12 months).

☐ **Permanently limited or impaired.** A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Uses portable oxygen.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.

☐ Has a cardiac condition to the extent that functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

☐ Is restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 millimeters of mercury on room air at rest.

☐ Has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder.

☐ Has been diagnosed with Alzheimer's disease or another form of dementia.

☐ Is legally blind or deaf.

☐ Other condition that limits or impairs the ability to walk, or creates a safety concern while walking because of impaired judgement or other physical, developmental, or mental limitation (Specific condition description must be specified below).

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

Reason this patient's ability to walk is limited or impaired. (check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.

☐ Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.

☐ Other condition that limits or impairs the ability to walk (Specific condition description must be specified below).

LICENSED MEDICAL PROFESSIONAL CERTIFICATION

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Chiropractor ☐ Podiatrist

MEDICAL PROFESSIONAL NAME (print)		OFFICE TELEPHONE NUMBER ( )	OFFICE FAX NUMBER ( )
LICENSE TYPE	LICENSE NUMBER	LICENSE EXPIRATION DATE (required)	STATE ISSUING LICENSE (required)
MEDICAL PROFESSIONAL SIGNATURE			DATE (mm/dd/yyyy)

Application for Disability Parking Tags & Placard

Use this form to apply for disability parking tags (license plates), placard or both.

What are you requesting?

Check only one: ☐ New Application ☐ Renewal

Check all that apply: ☐ Disability Parking Tags 

☐ Disability Parking Placard 

Tell us about yourself.

First Name:	**Middle Name:**	**Last Name:**
Address:	Washington, DC	**ZIP:**
Date of Birth:	**SSN:**	**Phone:**
Email:		

I confirm that my application is true to the best of my knowledge. I understand that my disability parking tags and/or placard is/are for my use only and are non-transferable. A designated driver may display the placard only if I am a passenger.

Signature: _____ **Date:** _____

Who will certify your disability? *(check only one)*

A false statement on this form is a violation of DC law and subject to a fine of up to $1,000, imprisonment up to 180 days or both.

☐ I am **self-certifying** in-person at a DMV Service Center that I am missing a lower extremity and/or am unable to walk without the aid of a motorized wheelchair.

☐ A **medical practitioner** has examined me and completed the following questions:
This application MUST BE postmarked/hand-delivered/emailed within 60 calendar days from when a medical practitioner completes this section.

Medical practitioner must complete if not self-certifying

Does the person have a mobility impairment or limitation? ☐ Yes ☐ No

Is the person limited in the ability to move without mobility aids (e.g. wheelchair, walker, crutches, cane, or long leg braces)? ☐ Yes ☐ No

Does the person have a respiratory condition and/or other disease that limits mobility? ☐ Yes ☐ No

Is the person's mobility impairment temporary or long-term? ☐ Temporary: _____ to _____ ☐ Long-term

Please describe in detail the nature & extent of the person's mobility impairment.

Practitioner's Signature:	**Date:**	**Phone:**
Practitioner's Name:	**Practitioner's ID #:**	

Submit your application.

***Placard**: No fee. | **Tags**: Include $10 fee (check or money order payable to "DC Treasurer").*

If you are **self-certifying** your mobility limitation:

- Bring this completed form and payment *(if applicable)* to a DMV Service Center.

If a **medical practitioner** is certifying your mobility limitation:

- For placards: Submit the application online at bit.ly/disabilityplacardtagform; or fax it to (202) 673-9908.
- For tags: Mail the application and payment to:
- DC Department of Motor Vehicle | PO Box 90120 | Washington, DC 20090.

MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

VR-210 (10-24)

Application for Maryland Parking Placards/License Plates

For quickest processing of your disability placard, upload this form to our online services portal at:
https://mymva.maryland.gov/TAP/IND/?Link=Disability

Please read instructions on back carefully before completing form.

A. Customer Identifying Information - Individual with a Disability

Requested Service: New Replacement Lost Placard(s) Stolen Placard(s)

Placard Number(s):	Police Report Number of Stolen Placard(s):	Jurisdiction Reported:

Parking Placard: One Two	Temp. Parking Placard: One Two	License Plate: One	Motorcycle Plates (In Glen Burnie Rm. 104 only) One Two

First Name:	Middle Name:	Last Name:

Date of Birth:	Driver's License/Identification Number:

Residence Street Address:	City:	County:	State:	Zip Code:

Mailing Street Address (if different):	City:	County:	State:	Zip Code:

If Guardianship, Guardian's First Name:	Middle Name:	Last Name:

Date of Birth:	Driver's License/Identification Number:

Attention: I/we certify the statements made herein are true and correct to the best of my/our knowledge, information and belief. I/we understand it is illegal for anyone to park in any parking space designated for a person with a disability, other than an individual who has submitted and obtained a certification from the MVA, that authorizes the use of a designated parking space. I/we also understand that the individual who has been certified to have a disability must have a current disability certification card in his or her possession when using a disability placard or plate.

I further understand that applying for a disability placard or plate and by execution of this authorization, I give permission to my doctor to release to the Motor Vehicle Administration all medical information relative to the qualification requirements that established my eligibility to obtain the disability placard or plate. Additionally, I agree to release the MVA from any and all liability that may arise from the collection and storage of medical information, in the procurement of this application. This authorization will not expire unless all disability placards and plates in my possession are expired or I have returned all placards and plates for cancellation.

Signature of Individual with Disability or Guardian of Individual with Disability Date

B. Vehicle Owner Information (for plates only) - By signing above, I certify that I understand that my vehicle may be parked in a parking space reserved for a disabled person only when the individual named above is present and in possession of a current Disability Certification Card.

Vehicle Title Number:	Motorcycle #1 Title Number:	Motorcycle #2 Title Number:

C. Disability Certification Information (doctor's use only - see disability codes)

Please note if your patient has a temporary disability, you should only recommend a temporary placard for a period of 1-6 months. If an extension is required, your patient can apply for an additional period of disability, for up to six months. This will require the approval of the appropriate clinician. A permanent disability status should be reserved for conditions that will not improve.

Type of Disability: Permanent Temporary 100% Disabled Veteran

Patient Name:	Disability Code:	Length of Temporary Disability: months	Reason for Temporary Disability (Temp. Placard only):

Office Address:	City:	County:	State:	Zip Code:	Phone Number:

Email Address:	Medical License Number:	State of Issue:	Expiration Date

Type of Doctor: Licensed Physician Licensed Chiropractor Licensed Optometrist Licensed Podiatrist
Licensed Nurse Practitioner Licensed Physician's Assistant Licensed Physical Therapist

Doctor/Nurse Practitioner's Name (printed) Signature Date

Instructions:

Purpose: An individual with a disability may use this form to request placards, license plates and/or motorcycle plates that will allow a vehicle in which he/she is riding to park in a parking space reserved for the disabled. Two types of placards are available: Temporary Placards (red), which are valid for a period of up to 6 months; and Permanent Parking Placards (blue), which are valid until the death of the disabled individual. An applicant may request a parking placard, license plate and motorcycle plates at the same time. See the Form Completion Instructions below.

Fee Information:
Placard: There is not a fee for the placard(s).
Plates: A request for a disability plate and/or motorcycle plate requires the assessment of the substitute/replacement tag fee. Please submit your completed application along with the appropriate $20.00 fee. If requesting a disability plate and/or motorcycle plate(s) and it's time to renew your vehicle registration, the registration fee is also required.

What can I apply for?

An individual with a permanent disability may apply for:

- One placard, or
- One regular disability plate, or
- One placard and one regular disability plate, or
- Two placards

In addition, up to two motorcycle disability plates can be requested with any combination listed above.

An individual with a Temporary disability may apply for:

- One or two temporary placards

What sections should I fill out?

Parking Placard - Complete Section A. An approved medical provider needs to complete Section C.

License Plates or Motorcycle Plates - Complete Sections A & B. An approved medical provider needs to complete Section C. You may only request a disability plate or motorcycle plate(s) if the vehicle is titled in the name of the individual with a disability.

Note:

- A doctor's certification may not be required if the individual has a disability that meets the definition of code 6 or V.
- For a replacement placard, only complete section A. For replacement plates, complete sections A & B.
- For temporary placards, Disability Code 10 is to be used.

Permanent Disability Codes

1. Has lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or arterial oxygen tension (p02) is less than 60 mm/hg on room air at rest.	6. Has lost an arm, hand, foot or leg (**See Note D**)
	7. Has lost the use of an arm, hand, foot or leg.
2. Has cardiovascular disease limitations classified in severity as Class III or Class IV according to standards set by the American Heart Association.	8. Has a permanent disability, that adversely impacts the ambulatory ability of the applicant and which is so severe that the person would endure a hardship or be subject to a risk of injury if the privileges accorded a person for whom a vehicle is specially registered were denied.
3. Is unable to walk 200 feet without stopping to rest.	9. Has a permanent impairment of both eyes so that: 1) The central vision acuity is 20/200 or less in the better eye with corrective glasses, or 2) There is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees in the better eye (**See Note C**)
4. Is unable to walk 200 feet without the use of, or the assistance from, a brace, cane, crutch, another person, prosthetic device, or other assistance device.	
5. Requires a wheelchair for mobility	10. **Temporary Placard -** Disability is not permanent but would substantially impair the person's mobility or limit or impair the person's ability to walk for at least three weeks, and is so severe that the person would endure a hardship or be subject to risk of injury if the Temporary Permit was denied.

Reserved for use by veterans with 100% disability. The Veterans Administration has certified by letter that the applicant has a 100% service connected disability. A letter from the Veterans Administration indicating the disability percentage must be submitted with this form.

Notes:

A. A licensed physician, licensed nurse practitioner or licensed physician's assistant may certify all qualifying conditions listed.

B. A licensed chiropractor, licensed podiatrist or licensed physical therapist may certify disability codes 3 through 8, and 10.

C. A licensed optometrist may certify only qualifying conditions regarding vision.

D. The person with a disability may self-certify the conditions listed under Disability Code 6 by appearing in person with proper identification. In this situation, only the disabled person's name and Disability Code must be recorded. If, however, a doctor certifies the loss of a limb, the doctor must complete all of Section C.

If someone other than the applicant submits the application for Disability Plates or Placards they must provide a state issued ID. Applications may also be mailed with the appropriate fees to the Motor Vehicle Administration, 6601 Ritchie Highway N.E., Glen Burnie, Maryland 21062 Attn: Disability Unit.

MY CRISIS PLAN

NAME:

MY LOVED ONES:

- ATTORNEY:
- DOCTOR:
- HEALTH INSURANCE INFORMATION:
- IN CASE I HAVE TO LEAVE HOME, I WILL GO TO:
- ADDITIONAL INFORMATION/COMMENTS:

LOCAL RESOURCE INFORMATION

- LOCAL CRISIS HOTLINE:
- LOCAL DOMESTIC VIOLENCE HOTLINE:
- HDSA SOCIAL WORKER:
- POLICE:
- SUICIDE HOTLINE:

GEORGETOWN UNIVERSITY
Georgetown University Medical Center
1789
Huntington's Disease Society of America
Center of Excellence
Medstar/Georgetown University
MedStar Health

National Resources

Huntington's disease

Huntington's Disease Society of America (HDSA)
HDSA provides information, resources and downloadable publications. Call HDSA to locate an HD social worker in your area.

www.hdsa.org
888-HDSA-506

Legal Resource Websites

Legal Services Corporation
The Legal Services Corporation has a state by state listing of legal aid societies and other providers of low cost or no cost legal assistance.

www.lsc.gov

Find Law
Find Law has a searchable database of legal information, as well as a listing of lawyers.

www.findlaw.com

Law Help
Law Help has a local listing of agencies that provide free legal aid programs and answer questions about legal rights.

www.lawhelp.org

Crisis Hotlines

Safe Horizon
Safe Horizon, the largest victim services agency in the U.S. , provides support and advocacy for victims of crime and abuse.

www.safehorizon.org

Domestic Violence Hotline:
800-621-HOPE (4673)

Safe Horizon's Crime Victims Hotline:
866-689-HELP (4357)

Rape Abuse and Incest National Network (RAINN)
The Rape, Abuse & Incest National Network is the nation's largest anti-sexual assault organization. RAINN has a telephone and an online hotline and provides referrals to local resources.

www.rainn.org
800-621-HOPE (4673)

National Domestic Violence Hotline
The National Domestic Violence Hotline is a 24-hour hotline providing support through advocacy, safety planning and local resources

www.thehotline.org
800-799-SAFE (7233)

Suicide Prevention Hotline
www.suicidepreventionlifeline.org
800-273-TALK (8255)