Office of the Public Guardian for Elderly Adults of New Jersey

PHYSICIAN QUESTIONNAIRE FOR GOALS OF TREATMENT

Phone Number: (609) 588-6500   Fax Number: (609) 588-7044

Patient ___________________________ Age _________ DOB _______________ Gender □ F □ M

Current Location ____________________________

Permanent Location ____________________________

Diagnosis:

- [ ] Dementia
- [ ] Hypertension
- [ ] COPD
- [ ] Diabetes
- [ ] CHF
- [ ] Parkinson's
- [ ] Renal Disease
- [ ] CVA
- [ ] Pneumonia
- [ ] TIA
- [ ] Cancer Type: ____________________________ Stage: ______________
- [ ] Other (please explain): ____________________________

Current Level of Pain:

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe

Pain Medications/Interventions: ____________________________

Current Level of Functioning (include evidence of any changes in conditions): ____________________________

Specialist Consultations: ____________________________

With reasonable medical certainty, is the patient’s life expectancy approximately one year or less? Please elaborate:

Are you aware of any previous verbal or written statements by this patient concerning Life Sustaining Treatment? Have you had any communication with family members or friends?

Life Sustaining Treatment

At the current time I am recommending the following:

- Patient should be designated as Do Not Resuscitate: □ Yes □ No
- Patient should be designated as Do Not Hospitalize: □ Yes □ No
- Patient should be evaluated for Hospice Services: □ Yes □ No
- Artificial Nutrition should be …………………….Withheld: □ Yes □ No Withdrawn: □ Yes □ No
- Artificial Hydration should be …………………….Withheld: □ Yes □ No Withdrawn: □ Yes □ No
- Artificial Ventilation should be …………………….Withheld: □ Yes □ No Withdrawn: □ Yes □ No
- Intubation should be …………………….Withheld: □ Yes □ No Withdrawn: □ Yes □ No
- Life sustaining medication should be ………….Withheld: □ Yes □ No Withdrawn: □ Yes □ No
Patient

Do you agree that the burdens and risks of treatment outweigh any benefit the patient might derive? □ Yes □ No

Please elaborate: _____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Goals of Treatment: __________________________________________________________
__________________________________________________________________________

Prognosis with Treatment: _____________________________________________________
__________________________________________________________________________

Prognosis without Treatment: _________________________________________________
__________________________________________________________________________

Name of Physician (Print): ____________________________________________________

SIGNATURE: ____________________________________________________________________ Date: ____________________________________________________________________

Phone Numbers: __________________________________________________________________

How long have you been treating the patient? __________________________________________________________________

□ Attending in Hospital □ Facility Physician □ Hospitalist □ Primary Care

SECOND PHYSICIAN

As a second opinion, I concur with the proposed treatment plan stated above. I also concur with the recommendations made regarding Life Sustaining Treatments because:

__________________________________________________________________________
__________________________________________________________________________

Name of Physician (Print): ____________________________________________________

SIGNATURE: ____________________________________________________________________ Date: ____________________________________________________________________

Phone Numbers: __________________________________________________________________

Medical Specialty: __________________________________________________________________

SIGNATURE OF PUBLIC GUARDIAN OR DESIGNEE: ___________________________ Date: ___________________________