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**

☐ Initial
☐ Update

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Artificial Nutrition should be.....Withheld:	☐ **Yes**	☐ **No**	Withdrawn:	☐ **Yes**	☐ **No**
Artificial Hydration should be.....Withheld:	☐ **Yes**	☐ **No**	Withdrawn:	☐ **Yes**	☐ **No**
Artificial Ventilation should be .....Withheld:	☐ **Yes**	☐ **No**	Withdrawn:	☐ **Yes**	☐ **No**
Intubation should be.....Withheld:	☐ **Yes**	☐ **No**	Withdrawn:	☐ **Yes**	☐ **No**
Life sustaining medication should be .....Withheld:	☐ **Yes**	☐ **No**	Withdrawn:	☐ **Yes**	☐ **No**

PHYSICIAN QUESTIONNAIRE FOR GOALS OF TREATMENT
(Continued)

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: _____