PHYSICIANS RECOMMENDATION FOR END OF LIFE CARE

A. Clients Name:_____ **Diagnoses**: _____
SSN:_____ _____
Date of Birth:_____ _____

B. Attending Physicians Information
Physicians printed name with title completing this form:_____
Physicians address:_____
Physicians telephone number:_____
Physicians Signature _____
Date form completed by Attending Physician:_____

C. Recommendation is for PLEASE MARK YES FOR ALL THAT APPLY:
Hospice Care **YES ___ NO ___** Withholding of Care **YES ___ NO ___**
Comfort Care Measures **YES ___ NO ___** Termination of Life Prolonging Treatment **YES ___ NO ___**

D. Reason for Recommendation PLEASE MARK YES FOR ALL THAT APPLY:
The client has an irreversible terminal condition. **YES ___ NO ___**
Death is imminent, by reasonable medical judgement, within a few days. **YES ___ NO ___**
The ward is in a permanently unconscious state or persistent vegetative state. **YES ___ NO ___**
The burden of the provision of life prolonging treatment outweighs the benefit. **YES ___ NO___**

E. Treatment Measures recommended PLEASE MARK YES FOR ONE OF THE FOLLOWING:
Full treatment: to include intubation, advanced airway interventions, mechanical ventilation, defibrillation, cardioversion, medical treatments, IV fluids, transfer to hospital. Includes palliative measures to reduce or eliminate the wards discomfort and pain. **YES ___ NO ___**
Limited additional intervention: use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. Includes palliative measures to reduce or eliminate the wards discomfort and pain. **YES ___ NO ___**
Comfort measures: keep clean, warm, and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to the hospital unless comfort needs cannot be met in the patient's current location. **YES ___ NO ___**

F. Antibiotic Administration PLEASE MARK YES FOR ONE OF THE FOLLOWING:
Antibiotics as indicated for the purpose of maintaining life **YES ___ NO ___**
Antibiotics for treatment of infection **YES ___ NO ___**
Antibiotics only to relieve pain and discomfort **YES ___ NO ___**
No antibiotics **YES ___ NO ___**

G. Administration of IV Fluids PLEASE MARK YES FOR ONE OF THE FOLLOWING:
Long term IV fluids **YES ___ NO ___**
Goal oriented/ temporary IV fluids **YES ___ NO ___**
No IV fluids **YES ___ NO ___**

H. Administration of Artificial Nutrition/ Feeding Tube PLEASE MARK YES FOR ONE OF THE FOLLOWING:
Long term feeding tube **YES ___ NO ___**
Goal oriented/ temporary feeding tube **YES ___ NO ___**
No feeding tube **YES ___ NO ___**

I. Consulting Physicians Information: COMPLETE THIS SECTION IF YOU ARE IN AGREEMENT WITH THE ABOVE RECOMMENDATIONS
Consulting Physicians printed name with title:_____
Consulting Physicians address:_____
Consulting Physicians telephone number:_____
Consulting Physicians Signature _____
Date form completed by Consulting Physician: _____