End of Life Care Sample Letter

Physicians Name

Physicians Address

Physicians City/state/zip

Physicians Phone/fax

To whom it may concern,

(Patient name) is a **(age / sex)** who is currently a patient at **(facility name)**. I am recommending **(comfort measure/hospice/withdraw of life support/termination of life support)** due to the patient's poor prognosis and short life expectancy. Life expectancy estimated at less than **(# days/weeks/ months)**.

(Patient name) suffers from **(patient history)**. **She/He** appears to be in pain with routine care and treatment. The patient is **(paint a picture of the patient's current medical status. Examples include unresponsive, bed bound, contracted, non-verbal, recurrent hospital admissions, requires total assist with all ADL's, etc.)**. Despite aggressive treatment including **(IV antibiotics, medication adjustments, Bipap, Steroids, Nebs, etc.)**, the patient continues to decline and is no longer responding to treatment. Therefore, I am recommending treatments be stopped and patient be kept comfortable.

Continuing aggressive treatment would only prolong suffering and would not improve quality of life. **Patient name** will continue to be provided with **(what will be provided to the patient during this time; comfort meals despite patient refusal, pain medication as needed to ease suffering, oral care, foley catheter, etc;)**

Due to the short life expectancy and poor quality of life, I ask that you consider my recommendations.

(MD signature)

(MD Printed Name)

(Date)