DC HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

ATTENDING PHYSICIAN'S COMPLIANCE FORM

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MIDDLE)		PATIENT ID #	DATE OF BIRTH:
MEDICAL DIAGNOSIS			PATIENT SOCIAL SECURITY NUMBER
EDUCATION LEVEL, if known	RACE	HISPANIC ORIGIN? ☐	SEX
INSURANCE CARRIER			TERMINAL DISEASE

B PHYSICIAN INFORMATION

NAME (LAST, FIRST, M.I.)	D.C. LICENSE NUMBER	BUSINESS TELEPHONE NUMBER ( ) —
BUSINESS ADDRESS		
CITY, STATE AND ZIP CODE		

C ACTION TAKEN TO COMPLY WITH LAW

1. FIRST ORAL REQUEST

First oral request for medication to end life.	DATE
Comments:	

Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)

☐ 1. Determination that the patient has a terminal disease.
☐ 2. Determination the patient has six months or less to live.
☐ 3. Determination that patient is capable.**
☐ 4. Determination that patient is a District of Columbia resident.***
☐ 5. Determination that patient is acting voluntarily.
6. Determination that patient has made his/her decision after being fully informed of:
☐ a) His or her medical diagnosis; and
☐ b) His or her prognosis; and
☐ c) The potential risks associated with taking a covered medication; and
☐ d) The potential result of taking a covered medication; and
☐ e) The feasible alternatives, to taking a covered medication, including, comfort care, hospice care and pain control.

Indicate compliance by checking the boxes. DATE:

☐ 1. Patient informed of his or her right to rescind the request at any time.
☐ 2. Patient recommended to inform next of kin, friends, and spiritual advisor, if applicable, of his or her decision to request a covered medication.
☐ 3. Patient counseled about the importance of having another person present when the patient takes a covered medication.
☐ 4. Patient counseled about the importance of not taking a covered medication in a public place.

2. SECOND ORAL REQUEST (*Must be made at least **15 days** after the first oral request.*)

Indicate compliance by checking the boxes. DATE:

☐ 1. Second oral request for medication to end life.
☐ 2. Patient informed of the right to rescind the request at any time.

Comments:

ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

C ACTION TAKEN TO COMPLY WITH THE LAW – continued

3. PATIENT'S WRITTEN REQUEST

☐ Written request for medication to end life received. DATE

*(No less than **48 hours** shall elapse between the written request and writing the prescription.)*

Comments:

D MEDICAL CONSULTATION (Upload consultant's form.)

Medical consultation and second opinion requested from:

MEDICAL CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

E PSYCHIATRIC/PSYCHOLOGICAL EVALUATION

*Check one of the following **(required)**:*

☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in conformance with D.C. Official Code § 7-661.01 et seq. Counseling Referral.

☐ I have referred the patient to the provider listed below for evaluation and consulting for a possible psychiatric or psychological disorder, or depression causing impaired judgment, **and attached the consultant's form.**

PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE
PSYCHOLOGIST CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

F MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

*(To be prescribed no sooner than **48 hours** after patient's written request has been signed.)*

Covered medication prescribed and dose — DATE PRESCRIBED

Please check one of the following:

☐ Dispensed medication directly. **Date**_____/_____/_____

☐ Contacted pharmacist and delivered prescription personally or by telephone, facsimile, or electronically to the pharmacist.

Pharmacy Name	**Business Address**	**City**	**State**	**Phone** ( ) -

Immediately prior to writing the prescription, the patient was fully informed of: (*check boxes*)

☐ (a) his or her medical diagnosis;

☐ (b) his or her prognosis;

☐ (c) the potential risks associated with taking the medication to be prescribed;

☐ (d) the probable result of taking a covered medication;

☐ (e) the feasible alternatives, to taking a covered medication, including, comfort care, hospice care and pain control.

To the best of my knowledge, all of the requirements under the Death with Dignity Act of 2016 (D.C. Law 21-182, D.C. Official Code § 7-661.01 *et seq.*) have been met.

X	PHYSICIAN'S SIGNATURE (Electronic signature)	DATE

* If comments in any section exceed the space provided, please use an attached page. Supplemental comments should be identified using the appropriate alpha-numeric notation (e.g., C1).

** "Capable" means that, in the opinion of a court or the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.

*** Factors demonstrating residency include, but are not limited to: 1) Possession of a District of Columbia driver's license; 2) Evidence that a person leases/owns property in the District of Columbia; or 3) Filing of District of Columbia tax return for the most recent tax year. Only the attending physician is required to affirm District of Columbia residency.

March 14, 2018