

ATTENDING PHYSICIAN'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics, P.O. Box 47856, Olympia, WA 98504-7856

Α	PATIENT INFORMATION				
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:			
	MEDICAL DIAGNOSIS				
В	B PHYSICIAN INFORMATION				
	NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER			
		() —			
	MAILING ADDRESS				
	CITY, STATE AND ZIP CODE				
_					
С	ACTION TAKEN TO COMPLY WITH LAW				
	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 competent.*				
	4. Determination that patient is a Washington state 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 the medication to be prescribed; and				
	d) The potential result of taking the medication to be prescribed; and				
	 e) The feasible alternatives, including, but not limited to, comfort care, hospice care Indicate compliance by checking the boxes. 	and pain control. DATE:			
	1. Patient informed of his or her right to rescind the request at any time.	DATE.			
	2. Patient recommended informing next of kin.				
	3. Patient counseled about the importance of having another person present when the patient takes the medication(s).				
	4. Patient counseled about the importance of not taking the medication in a public place.				
	2. SECOND ORAL REQUEST (Must be made 15 days or more 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:				

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ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

PATIENT INFORMATION				
	PATIENT'S NAME (LAST, FIRST, M.I.)		DATE OF BIRTH	
С	ACTION TAKEN TO COMPLY WITH THE LAW – continued 3. PATIENT'S WRITTEN REQUEST			
	Written request for medication to end life received. Please attach request. (<i>No less</i>	DATE		
	hours shall elapse between the written request and writing the prescription.)			
	Comments:			
D	MEDICAL CONSULTATION (Attach consultant's form.) Medical consultation and second opinion requested from:			
	MEDICAL CONSULTANT'S NAME TELEPHONE NUMBE	R	DATE	
E	PSYCHIATRIC/PSYCHOLOGICAL EVALUATION Check and of the following (verying d):			
	 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 accordance with chapter 70.245 RCW. 			
	I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment, and attached the consultant's form .			
	PSYCHIATRIC CONSULTANT'S NAME TELEPHONE NUMBER	R	DATE	
	() –			
F	MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT			
	(To be prescribed no sooner than 48 hours after patient's written red	quest has been si		
	LETHAL MEDICATION PRESCRIBED AND DOSE		DATE PRESCRIBED	
	Please check one of the following:			
	Dispensed medication directly. Date //			
	Contacted pharmacist and delivered prescription personally or by mail to the pharm Pharmacy Name City Pl	acist. none #()	-	
	Immediately prior to writing the prescription, the patient was fully informed of: (check box	res)		
	(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 the medication to be prescribed;			
	(e) the feasible alternatives, including, but not limited to, comfort care, hospice care	e and pain contro	ıl.	
	To the best of my knowledge, all of the requirements under the Washington Death with Dignity Act have been met.			
	PHYSICIAN'S ORIGINAL SIGNATURE	J, :	DATE	
	X THISIOIAN S ORIGINAL SIGNATURE			

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^{* &}quot;Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

^{**} Factors demonstrating residency include, but are not limited to: 1) Possession of a Washington State driver's license; 2) Registration to vote in Washington State; 3) Evidence that a person owns or leases property in Washington State.