ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

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

Dear Physician:

The Washington Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication under the Act to report to the Department of Health information that documents compliance with the law. The attending physician shall complete this form within thirty calendar days of a patient's ingestion of a lethal dose of medication obtained pursuant to the act or death from any other cause, whichever comes first. If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All individual information will be kept strictly confidential. Aggregate information will be provided on an annual basis. If you have questions about these instructions, please call 360-236-4324.

Physician's Name: _____

Date: ____/____/_____(MM/DD/YY)

Patient Name: _____

Date of Patient's Death: ____/____/____ (MM/DD/YY)

County of Death: _____

1. What was the patient's underlying illness?

   _____

   _____

2. On what date did you begin caring for this patient?

   ____/____/____ (MM/DD/YY)

3. On what date was the patient first told about their underlying medical condition?

   ____/____/____ (MM/DD/YY)

4. On what date was the patient told they have a terminal disease – meaning an incurable and irreversible disease that will within reasonable medical judgment produce death within six months?

   ____/____/____ (MM/DD/YY)

5. What type of health-care coverage did the patient have for their underlying illness? (C*heck all that apply.*)

☐ 1 Medicare
☐ 2 Medicaid
☐ 3 Military/CHAMPUS
☐ 4 V.A.
☐ 5 Indian Health Service
☐ 6 Private insurance
☐ 7 No insurance
☐ 8 Had insurance, don't know type
☐ 9 Unknown

6. When the patient initially requested a prescription for the lethal dose of medication, was the patient receiving hospice care?

☐ 1 Yes
☐ 2 No, refused care
☐ 3 No, other (specify) _____
☐ 9 Unknown

7. Seven possible concerns that may have contributed to the patient's decision to request a prescription for the lethal dose of medication are shown below. Please check "Yes", "No", or "Don't know", depending on whether or not you believe that concern contributed to the request.

A concern about:

...the financial cost of treating or prolonging his or her terminal condition.
☐ Yes ☐ No ☐ Don't Know

...the physical or emotional burden on family, friends, or caregivers.
☐ Yes ☐ No ☐ Don't Know

...his or her terminal condition representing a steady loss of autonomy.
☐ Yes ☐ No ☐ Don't Know

...the decreasing ability to participate in activities that made life enjoyable.
☐ Yes ☐ No ☐ Don't Know

...the loss of control of bodily functions, such as incontinence and vomiting.
☐ Yes ☐ No ☐ Don't Know

...inadequate pain control at the end of life.
☐ Yes ☐ No ☐ Don't Know

...a loss of dignity.
☐ Yes ☐ No ☐ Don't Know

8. On what date was the prescription for a lethal dose of medication written or phoned in?

___/____/___(MM/DD/YY)

9. What medication was prescribed and what was the dosage?

_____

_____

10. On what date was the lethal dose of medication dispensed to the patient?

___/____/___(MM/DD/YY) ☐ Not Dispensed ☐ Unknown

11. Did the patient ingest the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No (If no, then please skip to question 22)

12. Were you with the patient when they took the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No, did not offer to be present at the time of ingestion
- ☐ 3 No, offered to be present, but the patient declined
- ☐ 8 No, other (specify): _____

If no: Was another physician or trained health care provider or volunteer present when the patient ingested medication?

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer (specify):

  _____
- ☐ 3 No
- ☐ 9 Unknown

13. Were you with the patient at the time of death?

- ☐ 1 Yes
- ☐ 2 No

If no: Was another physician or trained health care provider or volunteer present at the patient's time of death?

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer
- ☐ 3 No
- ☐ 9 Unknown

If no: How were you informed of the patient's death?

- ☐ 1 Family member called M.D.
- ☐ 2 Friend of patient called M.D.
- ☐ 3 Another physician
- ☐ 4 Hospice R.N.
- ☐ 5 Hospital R.N.
- ☐ 6 Nursing home/Assisted-living staff
- ☐ 7 Funeral home
- ☐ 8 Medical Examiner
- ☐ 9 Other (specify):_____

14. Did the patient take the lethal dose of medication according to the prescription directions?

- ☐ 1 Yes
- ☐ 2 No

If no: Please list the medications the patient took (other than those reported in item 10), the dosages, and the reason for not following the prescription directions.

_____

_____

_____

- ☐ 9 Unknown

15. Were there any complications after the ingestion of the lethal dose of medication, for example, vomiting, seizures, or regaining consciousness?

☐ 1 Yes (please describe):

_____

_____

_____

☐ 2 No
☐ 9 Unknown

16. Was the Emergency Medical System activated for any reason after the ingestion of the lethal dose of medication?

☐ 1 Yes (please describe):

_____

_____

_____

☐ 2 No
☐ 9 Unknown

17. What was the time between ingestion of the lethal dose of medication and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

18. What was the time between ingestion of the lethal dose of medication and death?

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

Do you have any observations on why the patient lived for more than six hours after ingesting the medication?

_____

_____

_____

_____

19. *Immediately* prior to ingestion of the lethal dose of medication, what was the patient's mobility? (ECOG scale)

☐ 0 Fully active, no restrictions on pre-disease performance.
☐ 1 Restricted in strenuous activity, but ambulatory and able to carry out work.
☐ 2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.
☐ 3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.
☐ 4 Completely disabled, no self-care, totally confined to bed or chair.
☐ 9 Unknown

20. Where did the patient ingest the medication?

- ☐ 1 Private home
- ☐ 2 Assisted-living residence (including foster care)
- ☐ 3 Nursing home
- ☐ 4 Acute care hospital in-patient
- ☐ 5 In-patient hospice resident
- ☐ 6 Other (specify) _____
- ☐ 9 Unknown

21. At the time of ingestion of the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, other (specify) _____
- ☐ 9 Unknown

22. What is your medical specialty? (*Check all that apply.*)

- ☐ 1 Family Practice
- ☐ 2 Internal Medicine
- ☐ 3 Oncology
- ☐ 4 Other (specify) _____

23. How many years have you been in practice, not including any training periods, such as residency or fellowship?

Years: _____

24. And lastly, do you have any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

_____

_____

_____

Original Signature of Physician: _____

FOR OFFICIAL USE ONLY

CASE ID NUMBER: ☐ DWDA ☐ ILLNESS ☐ OTHER

PHYSICIAN ID NUMBER: