Case ID: _____ - _____ Attending ID: _____ _____ _____ _____ _____ ☐ **DWD** ☐ **Illness**
For ODPE use only.

Oregon Death with Dignity Act
Attending Physician Follow-up Form

Dear Physician:

The Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication to complete this follow-up form within **10 calendar days** of a patient's death, whether from ingestion of the lethal dose of medications obtained under the Act or from any other cause.

For DHS to accept this form, it must be signed by the Attending (Prescribing) Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the address on the last page. *All information is kept strictly confidential.* If you have any questions, call: 971-673-1150.

Date: ____/____/____ **Patient's Name:** _____

Name of Attending (Prescribing) Physician:_____

_____

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please contact the family or patient's representative.**

☐ 1 **Death with Dignity** (lethal medication) → ***Please sign below and go to page 2.***

Attending (Prescribing) Physician Signature_____

☐ 2 **Underlying illness** → ***There is no need to complete the rest of the form. Please sign below.***

Attending (Prescribing) Physician Signature_____

☐ 3 **Other** → ***There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death andsign.***

Please specify: _____
_____
_____

Attending (Prescribing) Physician Signature_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of medication.

Please read carefully the following to determine which situation applies to you. Check the box that indicates your scenario, and complete the remainder of the form accordingly.

☐ The Attending (Prescribing) Physician was present at the time of death.

→ The Attending (Prescribing) Physician must complete this form in its entirety and sign Part A and Part B.

☐ The Attending (Prescribing) Physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The Attending (Prescribing) Physician must complete and sign Part B of the form.

☐ Neither the Attending (Prescribing) Physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The Attending (Prescribing) Physician must complete and sign Part B of the form.

PART A: To be completed and signed by the Attending (Prescribing) Physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the lethal dose of medication?

- 1 Yes
- 2 No

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

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

2. Was the attending physician at the patient's bedside at the time of death?

- 1 Yes
- 2 No

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

- 1 Yes, another physician or licensed health care provider
- 3 No
- 9 Unknown

3. On what day did the patient consume the lethal dose of medication?

____/____/____ (month/day/year) ☐9 Unknown

4. On what day did the patient die after consuming the lethal dose of medication?

____/____/____ (month/day/year) ☐9 Unknown

5. Where did the patient ingest the lethal dose of 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

6. What was the time between lethal medication ingestion and unconsciousness?

Minutes: _____ or Hours: _____. Unknown

7. What was the time between lethal medication ingestion and death?

Minutes: _____ or Hours: _____. Unknown

If the patient lived longer than six hours, are there any observations on why the patient lived for more than six hours after ingesting the lethal dose of mediation? _____

_____

_____

8. Were there any complications that occurred after the patient took the lethal dose of medication? For example: vomiting, seizures, or regaining consciousness?

- □ 1 Yes – vomiting, emesis
- □ 2 Yes – seizures
- □ 3 Yes – regained consciousness
- □ 4 No complications
- □ 5 Other – please describe: _____
  _____
  _____
- □ 9 Unknown

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

- □ 1 Yes - please describe: _____
  _____
  _____
- □ 2 No
- □ 9 Unknown

10. At the time of ingesting the lethal dose of medication, was the patient receiving hospice care?

- □ 1 Yes
- □ 2 No, refused care
- □ 3 No, never offered care
- □ 4 No, other (specify) _____
- □ 9 Unknown

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

_____

_____

_____

_____

_____

Signature of Attending (Prescribing) Physician present at time of death:

_____

Name of Licensed Health Care Provider present at time of death if not Attending (Prescribing) Physician:

_____

Signature of Licensed Health Care Provider

_____

PART B : To be completed and signed by the Attending (Prescribing) Physician

12. On what date did the attending physician begin caring for this patient?
____/____/____ (month/day/year)

13. On what date was the prescription written for the lethal dose of medication?
____/____/____ (month/day/year)

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

- □ 1 Yes
- □ 2 No, refused care
- □ 3 No, never offered care
- □ 4 No, other (specify) _____
- □ 9 Unknown

15. Seven possible concerns that may have contributed to the patient's decision to request a prescription for lethal 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

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

- □ 1 Medicare
- □ 2 Oregon Health Plan/Medicaid
- □ 3 Military/CHAMPUS
- □ 4 V.A.
- □ 5 Indian Health Service
- □ 6 Private insurance (e.g., Kaiser, Blue Cross, Medigap)
- □ 7 No insurance
- □ 8 Had insurance, don't know type
- □ 9 Unknown

17. Are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

Signature of Attending (Prescribing) Physician:

Please mail this document to:
Center for Health Statistics
Oregon Department of Human Services
P. O. Box 14050
Portland, OR 97293-0050
Copies of this form are available at: http://oregon.gov/DHS/ph/pas/pasforms.shtml