SEND A COPY OF THIS FORM TO THE OREGON STATE PUBLIC HEALTH DIVISION

ATTENDING PHYSICIAN'S COMPLIANCE FORM

ORS 127.800 - ORS 127.897

MAIL FORM TO: Oregon State Public Health Division, Center for Health Statistics, P.O. Box 14050, Portland, OR 97293-0050

PLEASE PRINT

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
MEDICAL DIAGNOSIS	

B PHYSICIAN INFORMATION

NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
MAILING 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 an Oregon 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 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.
- ☐ 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

C ACTION TAKEN TO COMPLY WITH THE LAW – continued

3. PATIENT'S WRITTEN REQUEST

☐ Written request for medication to end life received. Please attach request. *(No less than **48 hours** shall elapse between the written request and writing the prescription.)*	DATE
Comments:	

D MEDICAL CONSULTATION (Attach 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 ORS 127.825.

☐ 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
	( ) —	

F MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

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

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 pharmacist.
Pharmacy Name City 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 the medication to be prescribed;

☐ (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

To the best of my knowledge, all of the requirements under the Death with Dignity Act have been met.

✗	PHYSICIAN'S 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., C3).

** "Capable" means that in the opinion of a court, or in the opinion of the patient's attending physician or consulting physician, a patient has the ability to make and communicate health care decisions 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 an Oregon driver's license; 2) Registration to vote in Oregon; 3) Evidence that a person leases/owns property in Oregon; or 4) Filing of an Oregon tax return for the most recent tax year. Only the attending physician is required to affirm Oregon residency.

*Note: Besides this form, **it is the attending physician's responsibility** to send the following documents to the Public Health Division: 1) Patient's written request; 2) Consulting physician's report; and 3) Psychiatric evaluation referral report (if performed).*

This form is revised periodically. To assure that you are using the most current version, please refer to: http://www.healthoregon.org/dwd