



# Patient Choice at End of Life — Consulting Physician Reporting Form

Deliver form to the attending/prescribing physician who will mail it to:

Vermont Department of Health, Vital Records


P.O. Box 70, Burlington, VT 05402-0070

PLEASE PRINT

A PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B REFERRING/PRESCRIBING PHYSICIAN INFORMATION	
NAME	TELEPHONE NUMBER (with area code)

C CONSULTING PHYSICIAN DETERMINATIONS	
Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)	
Confirmed the:	
<input type="checkbox"/>	a) diagnosis and prognosis;
<input type="checkbox"/>	b) patient is capable;*
<input type="checkbox"/>	c) patient is making an informed decision;
<input type="checkbox"/>	d) patient has made a voluntary request for medication to hasten his or her death.

D CONSULTANT'S INFORMATION	
NAME (Please print)	TELEPHONE NUMBER (with area code)
MAILING ADDRESS	
CITY, STATE, ZIP CODE	
To the best of my knowledge, all of the requirements under the Patient Choice at End of Life Act have been met.	
	PHYSICIAN'S SIGNATURE
	DATE

\* "Capable" means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available