ATTENDING PHYSICIAN'S COMPLIANCE FORM

ORS 127.800 - ORS 127.897
Send all forms to: OHA Center for Health Statistics
Email: DWDA.Forms@oha.oregon.gov / Fax: 971-673-5332 / Mail: 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	OUT-OF-STATE RESIDENT ☐ Yes ☐ No

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 FOR MEDICATION

Indicate compliance by checking the boxes

DATE

- ☐ 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[1]
- ☐ 4. Determination that patient is acting voluntarily
- ☐ 5. Determination that patient has made his/her decision after being fully informed of:
  - 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 potential result of taking the medication to be prescribed
  - 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

Comments:

2. SECOND ORAL REQUEST FOR MEDICATION

*Must be **15 days** or more after the first oral request unless patient is exempt[2]*
Indicate compliance by checking the boxes.

DATE:

- ☐ 1. Patient made second oral request for medication to end life
- ☐ 2. Patient informed of the right to rescind the request at any time

EXEMPT FROM WAITING PERIOD? [2] ☐ Yes ☐ No

Comments:

ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

PATIENT INFORMATION	
PATIENT'S NAME	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) *(Must be at least **48 hours** before writing the prescription unless patient is exempt[2])*	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 unless patient is exempt[2])*	
	Lethal medication(s) prescribed and dose	DATE PRESCRIBED
	Pharmacy Name:	**City**
	Immediately prior to writing the prescription, the patient was fully informed of: (check boxes) ☐ 1. His or her medical diagnosis ☐ 2. His or her prognosis ☐ 3. The potential risks associated with taking the medication to be prescribed ☐ 4. The probable result of taking the medication to be prescribed ☐ 5. 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.	
	X PHYSICIAN'S SIGNATURE	DATE

1. "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.

2. A patient is exempt from any waiting period that exceeds his/her life expectancy. The Attending Physician must have a medically confirmed certification of the imminence of the patient's death in the patient's medical record if any waiting periods are not completed.

IT IS THE ATTENDING PHYSICIAN'S RESPONSIBILITY *to send this and 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, visit http://www.healthoregon.org/dwd.