Washington State Department of HEALTH

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Instructions for the Consulting Qualified Medical Provider's Compliance Form

The Washington Death with Dignity Act (chapter 70.245 RCW) allows a qualified patient with a terminal illness with six months or less to live to request medication that the patient may self-administer to end their life. If you have questions about these instructions, contact DeathwithDignity@doh.wa.gov.

Consulting Qualified Medical Provider Requirements

As the consulting qualified medical provider, you:

- Examine the patient and their medical records to confirm whether a patient is qualified under the Death with Dignity Act.
- Refer the patient for counseling if appropriate.
- Complete and **return this form to the Attending Qualified Medical Provider** immediately after examination. Do not send the form to the Department of Health directly.

Qualified Patient Requirements

A qualified patient must be:

- At least 18 years of age.
- Competent - in the opinion of a court or in the opinion of the patient's attending qualified medical provider or consulting qualified medical provider, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- A resident of Washington State.
- Diagnosed with a terminal disease - an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Common documents that prove residency in Washington State include, but are not limited to: a driver's license, voter registration, a mortgage or rental agreement, or a utility bill.

Note for the Attending Qualified Medical Provider

The Death with Dignity Act only provides immunity from civil and criminal liability and disciplinary action for good faith compliance. You must submit the following completed forms **within 30 calendar days** of writing a prescription for a lethal dose of medication:

Send the completed forms to the Department of Health.

- **Online through REDCap:** https://redcap.link/DeathWithDignity**.**
- By fax: 360-200-7408
- By mail: Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Department of Health will contact you if the forms are missing information. We keep all information strictly confidential and only release aggregate information on an annual basis.

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Consulting Qualified Medical Provider's Compliance Form

The Consulting Qualified Medical Provider must send the completed form to the Attending Qualified Medical Provider. Unless otherwise specified, fill out all text fields and check all boxes to indicate you completed the task.

A. Patient Information

Patient Name (Last, First, M.I.): _____ Date of Birth: _____

Medical Diagnosis: _____ Patient Record Number: _____

B. Attending Qualified Medical Provider Information

Name (Last, First, M.I.) and Title: Phone Number:

_____ _____

C. Consulting Qualified Medical Provider's Report

Exam Date: _____ Comments: _____

Both the Attending and Consulting Qualified Medical Providers must make these determinations.

- ☐ The patient has a terminal disease.
- ☐ The patient has six months or less to live.
- ☐ The patient is competent.
- ☐ The patient is a Washington state resident.
- ☐ The patient is acting voluntarily.
- ☐ The patient made their decision after being fully informed.

I informed the patient of:

- ☐ the medical diagnosis
- ☐ the prognosis
- ☐ the potential risks associated with taking the prescription medication
- ☐ the potential result of taking the prescription medication
- ☐ the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control

D. Psychiatric/Psychological Evaluation

Check only one of the following:

- ☐ I determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in accordance with chapter 70.245 RCW.
- ☐ I referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.

Name (Last, First, M.I.) and Title: Phone Number: Date:

_____ _____ _____

E. Consulting Qualified Medical Provider Confirmation

Provider Signature: _____ Date: _____

Name (Last, First, M.I.): _____ Title: _____

Mailing Address (Street, City, State, And Zip Code): _____

Email Address: _____ Phone Number: _____