SUBJECT: WA "DEATH WITH DIGNITY ACT"	REFERENCE #
DEPARTMENT: DISTRICT WIDE	PAGE: 1 of 1
APPROVED BY: Tom Wilson, CEO	EFFECTIVE: 03/16/2017

Reviewed 4/6/2018

Newport Hospital & Health Services (NHHS) does not mandate nor will it encourage any provider to participate in the "Death with Dignity Act." However, NHHS will allow providers to participate under the Act, if they desire to participate. Providers at NHHS may:

- Perform the duties of an attending physician;
- Perform the duties of a consulting physician;
- Prescribe life-ending medication;
- Provide counseling in connection with the provision of life-ending medication;
- Perform other duties as provided for in the Act;

Providers ***may not***:

- Fill the prescription for life-ending medication.

If a NHHS provider does choose to participate under the "Death with Dignity Act," that provider must immediately notify the Chief Executive or designee. It is the provider's responsibility to ensure correct procedures are followed and the correct documentation is completed in accordance with the Act and hospital policy. While participating under the Act, any provider at NHHS must ensure the appropriate standard of care is followed. The steps included in the attached checklist should be followed carefully and documented appropriately.

Hospital administration may provide oversight and review records to any extent it deems necessary to ensure all safeguards of the law are followed and the required documentation is complete and submitted to the Department of Health.

While NHHS allows its providers to participate, it will prohibit patients from taking the medication in the hospital setting. And, while patients may receive a prescription from NHHS providers, it must be filled elsewhere. NHHS does not have a dispensing pharmacy and for safety reasons will not stock nor fill a prescription for life-ending medication.

End of Life Care: NHHS believes our providers have an obligation to openly discuss a patient's concerns, unmet needs, feelings, and desires about the dying process. All providers at NHHS are expected to respond to any patient's query about end of life care, including life-ending medication, with openness and compassion. Providers should seek to learn the meaning behind the patient's questions and help the patient to understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, NHHS's goal is to help patients make informed decisions about end-of-life care.

Laws/Regulations:
Washington Death with Dignity Act – RCW 70.245
Washington State Department of Health Regulations - WAC 246-978

Newport Hospital & Health Services
Death w/Dignity - Checklist for Participating Providers

TRIGGER: Patient makes first request for lethal prescription.

ALL PERSONS:

- Continue to provide all appropriate care to patient within standard of care.
- Make choice whether to participate in fulfilling patient request.
  - No adverse consequences will result from choice to not participate.
  - Transfer patient care, and any records, to another provider acceptable to patient.
- Document required steps on DOH forms and include copy of forms in medical record.
  - Steps that must be documented on a DOH form are indicated by 🗐.
  - Steps required by law, but which do not have to be documented on a DOH form, are indicated by [L]. These steps should be documented in medical record in order to support the immunity that accompanies compliance with the law.

Primary Physician - Stage One:

- It is the responsibility of the attending physician "to ensure all appropriate steps are carried out in accordance with the law before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner." [L]
- 🗐 Document patient first oral request, including date, time, and persons present, in medical record/DOH Form 422-064: "***Attending Physician's Compliance Form.***". Continue use of ***Attending Physician's Compliance Form*** to track completion of required steps.
- 🗐 Inform patient that patient may rescind request or end process to obtain a prescription any time and for any reason patient wishes.
- 🗐 Recommend patient notify next of kin of request.
- 🗐 Discuss with patient the patient's diagnosis and his or her prognosis.
- 🗐 Discuss feasible alternatives with patient and provides information on hospice, comfort care, and pain control.
- 🗐 Discuss with patient the risks associated with taking the medication to be prescribed.
- 🗐 Discuss with patient the probable result of taking the medication to be prescribed.
- 🗐 Determine that patient has an incurable and irreversible disease.
- 🗐 Determine, within reasonable medical judgment, that patient's incurable and irreversible disease will produce death within six months.
- 🗐 *Provide patient with the DOH written form for making final written request and explain time frame.*
- 🗐 Refer the patient to consulting physician for medical confirmation of diagnosis and determination that patient is competent to make informed decision and acting voluntarily.
- 🗐 Evaluate patient's competency and determine patient is competent to make an informed decision about self-administration of lethal medication.

- 🗐 Refer patient to licensed psychiatrist or psychologist for counseling if patient may have depression or psychiatric or psychological disorder causing impaired judgment.
    - Do not prescribe lethal medication unless and until person performing counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- Determine that patient request was made voluntarily.

Consulting Physician:

- Obtain DOH Form 422-065/CHS 603, "***Consulting Physician's Compliance Form.***" [L]
- Examine and evaluate patient clinical record. [L]
- 🗐 Examine and evaluate patient.
- 🗐 Confirm attending physician's diagnosis that patient has an incurable and irreversible disease.
- 🗐 Confirm that, within reasonable medical judgment, patient's incurable and irreversible disease will produce death within six months.
- 🗐 Confirm patient is competent to make an informed decision about self-administered lethal medication.
- 🗐 Refer patient to licensed psychiatrist or psychologist for counseling if patient may have depression or psychiatric or psychological disorder causing impaired judgment.
- 🗐 Confirm patient is acting voluntarily.
- 🗐 Confirm patient has made an informed decision to request self-administered lethal medication.
    - "Informed decision" means a decision that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
        - 🗐 His or her medical diagnosis;
        - 🗐 His or her prognosis;
        - 🗐 The potential risks associated with taking the medication to be prescribed;
        - 🗐 The probable result of taking the medication to be prescribed; and
        - 🗐 Feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- 🗐 Complete ***Consulting Physician's Compliance Form***, retain copy in medical record, and deliver original of form to the primary physician.

Counselor:

- Obtain DOH Form 422-066,"***Psychiatric/Psychological Consultant Compliance Form***". [L]
- Is a licensed psychiatrist or psychologist. [L]
- 🗐 Evaluate whether or not patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

- *Evaluate patient's competency to make an informed decision.*[1]
- *Provide, with patient consent, any appropriate treatment to patient to enable patient to make informed decision without impaired judgment.*[1]

- 🗐 Determine that patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- *Confirm patient has made an informed decision to request self-administered lethal medication.*[1]
  - *"Informed decision" means a decision that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:*
    - *His or her medical diagnosis;*
    - *His or her prognosis;*
    - *The potential risks associated with taking the medication to be prescribed;*
    - *The probable result of taking the medication to be prescribed; and*
    - *The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.*
- 🗐 Document evaluation on ***Psychiatric/Psychological Consultant's Compliance Form*** and sign determination; retain a copy for medical record; provide original to primary physician.

Primary Physician - Stage Two:

Document (in medical record) presence of all persons (family, treatment team, etc).[1]

- 🗐 Receive patient's second oral request.
- 🗐 Confirm 15 days or more have passed since patient's first oral request.
- Review consultant and counselor report(s). [L]
- Proceed only if consultant, and any counselor, confirm in report(s) that [L]
  - Patient has an incurable and irreversible disease.
  - Patient's incurable and irreversible disease will produce death within six months.
  - Patient is competent to make informed decision.
  - Patient is making an informed decision.
  - Patient is acting voluntarily.
  - Patient does not have depression or psychiatric or psychological disorder causing impaired judgment (if patient has been referred to counselor).
- 🗐 Receive patient's written request on DOH Form 422-063, "***Request for Medication to End My Life in a Humane and Dignified Manner***" (or in a written form that is substantially the same form as described in Act).
  - Confirm DOH form is complete, or that other written request substantially complies with the Act. [L]
  - Confirm form is signed by patient and witnesses at least 48 hours before physician writes prescription. [L]
  - Attach original patient written request form to ***Attending Physician's Compliance Form***. Retain copy in medical record. [L]

[1] Not required by law.

- 🗐 Confirm patient is Washington resident (*make copy of factor(s) used to determine residency and retain in medical record*[1]). Factors demonstrating Washington State residency include but are not limited to:
  - Possession of a Washington state driver's license;
  - Registration to vote in Washington state; or
  - Evidence that the person owns or leases property in Washington State.
- Confirm patient is at least 18 years of age. [L]
- *Inform the patient of importance of having another person present when patient takes the medication.*[2]
- *Inform the patient of importance of not taking the medication in a public place.*[2]
- 🗐 Specifically offer patient opportunity to rescind request. Specifically document offer and response.
- Verify that patient is still competent to make an informed decision. [L]
- Verify that patient is acting voluntarily. [L]
- 🗐 Immediately prior to writing prescription ensure that patient is fully informed/is making an informed decision.
  - "Informed decision" means a decision that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
    - 🗐 His or her medical diagnosis;
    - 🗐 His or her prognosis;
    - 🗐 The potential risks associated with taking the medication to be prescribed;
    - 🗐 The probable result of taking the medication to be prescribed; and
    - 🗐 The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- 🗐 Before writing prescription, determine that all required steps have been carried out and documented on required DOH forms and that copies are in the clinical record.
  - It is the responsibility of the attending (primary) physician "to ensure that all appropriate steps are carried out in accordance with the law before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner." [L]
- 🗐 Write prescription for self-administered lethal medication. With patient written consent[L] contact pharmacist and inform pharmacist of prescription AND deliver prescription in person, by fax, or by mail to pharmacist.
- 🗐 <u>Receive and deliver medication</u> directly to patient - including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort.
- Instruct patient that any unused medication must be disposed of legally. [L]
- 🗐 Complete and sign ***Attending Physician's Compliance Form***.

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[2] Law does not require this occur in Stage Two (however it is mandatory for Stage One).

- The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death (and not the ingestion of lethal medication). [L]
- Within 30 days after patient death, gather and submit required DOH forms: [L]
  1. 422-064: ***Attending Physician's Compliance Form.***
  2. 422-063: ***Request for Medication to End My Life in a Humane and Dignified Manner.***
  3. 422-066: ***Psychiatric/Psychological Consultant's Compliance Form***
  4. 422-065: ***Consulting Physician's Compliance Form***
  5. 422-067: ***Pharmacy Dispensing Record Form,*** only if physician dispenses medication directly. If physician refers to pharmacy for medication dispensing, the pharmacy will complete and submit this form.
- 🗐 Complete and submit required DOH Form 422-068, "***Attending Physician's After Death Reporting Form***" within 30 days after patient death or within 30 days after patient ingestion of lethal medication obtained pursuant to the Act (whichever comes first).
  - This form asks for very specific details about the patient's death and instructs physician to contact the family or patient's representative if physician does not know the answers to any of the questions.

Pharmacist:

- Receive notice from physician of prescription. [L]
- Receive prescription in person from physician or by fax or by mail. [L]
- Obtain DOH Form 422-067, "***Pharmacy Dispensing Record.***" [L]
- 🗐 Dispense prescribed medication.
- Provide medication to patient or to an agent expressly identified by the patient; or to the attending physician if indicated by physician. [L]
- Include notice with medication that any unused medication must be disposed of legally. [L]
- 🗐 Within 30 days of dispensing medication, complete and submit required DOH Form, 422-067, ***Pharmacy Dispensing Record.***

Washington State Department of Health

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____ am an adult of sound mind.
First Middle Last

I am suffering from _____, which my attending physician has determined is an incurable, irreversible terminal disease that will result in death within six months and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and dispense or to contact a pharmacist to dispense the prescription.

Initial One

- [ ] I have informed my family of my decision and taken their opinions into consideration.
- [ ] I have decided not to inform my family of my decision.
- [ ] I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation; and I accept full moral responsibility for my actions. I further declare that I am of sound mind and not acting under duress, fraud, or undue influence.

Signature:	County of Residence:	Date:

DECLARATION OF WITNESSES

By initialing and signing below in the presence of the person named above signs, we declare that the person making and signing the above request:

Witness 1	Witness 2	
[ ]	[ ]	1. Is personally known to us or has provided proof of identity;
[ ]	[ ]	2. Signed this request in our presence on the date following the person's signature;
[ ]	[ ]	3. Appears to be of sound mind and not under duress, fraud or undue influence;
[ ]	[ ]	4. Is not a patient for whom either of us is the attending physician.

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

NOTE: Only one of two witnesses may be a relative by blood, marriage, or adoption of the person signing this request, or be entitled to any portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident. The patient's attending physician at the time of the request is not eligible to be a witness. If the patient is an inpatient at a long-term health care facility, one of the witnesses shall be an individual designated by the facility.

Washington State Department of Health

ATTENDING PHYSICIAN'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics, P.O. Box 47856, Olympia, WA 98504-7856

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 competent.*
- ☐ 4. Determination that patient is a Washington state 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 informing 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:

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 accordance with chapter 70.245 RCW.		
	☐ I have referred the patient to the provider listed below for evaluation and counseling 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 Washington Death with Dignity Act have been met.	
	X PHYSICIAN'S ORIGINAL SIGNATURE	DATE

* "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, 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.

** Factors demonstrating residency include, but are not limited to: 1) Possession of a Washington State driver's license; 2) Registration to vote in Washington State; 3) Evidence that a person owns or leases property in Washington State.

Washington State Department of Health

CONSULTING PHYSICIAN'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:
State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

A PATIENT INFORMATION

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

B REFERRING/PRESCRIBING PHYSICIAN

REFERRING/PRESCRIBING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —

C CONSULTANT'S REPORT

1. MEDICAL DIAGNOSIS	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(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 competent.*
- ☐ 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; 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.

Comments:

D PATIENT'S MENTAL STATUS

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 chapter 70.245 RCW.
- ☐ I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.

PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

E CONSULTANT'S INFORMATION

X	PHYSICIAN'S ORIGINAL SIGNATURE	DATE
	NAME (PLEASE PRINT)	
MAILING ADDRESS		
CITY, STATE AND ZIP CODE		TELEPHONE NUMBER ( ) —

* "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, 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.

Washington State Department of Health

PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:
State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

A PATIENT INFORMATION

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

B REFERRING/PRESCRIBING PHYSICIAN

REFERRING PHYSICIAN'S NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: ( ) —

C PSYCHIATRIC / PSYCHOLOGICAL EVALUATION

1. MEDICAL DIAGNOSIS	DATE(S) OF EXAMINATION(S):

2. PSYCHIATRIC / PSYCHOLOGICAL EVALUATION

D PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION

I have determined through evaluation that the above-named patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment, in conformance with chapter 70.245 RCW.

X	CONSULTANT'S ORIGINAL SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):	
	CONSULTANT'S NAME (PRINTED):	DATE:

MAILING ADDRESS:	
CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: ( ) —

Washington State Department of Health

ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

Dear Physician:

The Washington Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication under the Act to report to the Department of Health information that documents compliance with the law. The attending physician shall complete this form within thirty calendar days of a patient's ingestion of a lethal dose of medication obtained pursuant to the act or death from any other cause, whichever comes first. If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All individual information will be kept strictly confidential. Aggregate information will be provided on an annual basis. If you have questions about these instructions, please call 360-236-4324.

Physician's Name: _____

Date: ____/____/____(MM/DD/YY)

Patient Name: _____

Date of Patient's Death: ____/____/____ (MM/DD/YY)

County of Death: _____

1. What was the patient's underlying illness?

   _____

   _____

2. On what date did you begin caring for this patient?

   ____/____/____ (MM/DD/YY)

3. On what date was the patient first told about their underlying medical condition?

   ____/____/____ (MM/DD/YY)

4. On what date was the patient told they have a terminal disease – meaning an incurable and irreversible disease that will within reasonable medical judgment produce death within six months?

   ____/____/____ (MM/DD/YY)

5. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)
   - ☐ 1 Medicare
   - ☐ 2 Medicaid
   - ☐ 3 Military/CHAMPUS
   - ☐ 4 V.A.
   - ☐ 5 Indian Health Service
   - ☐ 6 Private insurance
   - ☐ 7 No insurance
   - ☐ 8 Had insurance, don't know type
   - ☐ 9 Unknown

6. When the patient initially requested a prescription for the lethal dose of medication, was the patient receiving hospice care?
   - ☐ 1 Yes
   - ☐ 2 No, refused care
   - ☐ 3 No, other (specify) _____
   - ☐ 9 Unknown

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

8. On what date was the prescription for a lethal dose of medication written or phoned in?

   ___/____/____(MM/DD/YY)

9. What medication was prescribed and what was the dosage?

   _____

   _____

10. On what date was the lethal dose of medication dispensed to the patient?

    ___/____/____(MM/DD/YY) ☐ Not Dispensed ☐ Unknown

11. Did the patient ingest the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No (If no, then please skip to question 22)

12. Were you with the patient when they took the lethal dose of medication?

- ☐ 1 Yes
- ☐ 2 No, did not offer to be present at the time of ingestion
- ☐ 3 No, offered to be present, but the patient declined
- ☐ 8 No, other (specify): _____

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

- ☐ 1 Yes, another physician
- ☐ 2 Yes, a trained health-care provider/volunteer (specify):

_____

- ☐ 3 No
- ☐ 9 Unknown

13. Were you with the patient at the time of death?

- ☐ 1 Yes
- ☐ 2 No

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

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

If no: How were you informed of the patient's death?

- ☐ 1 Family member called M.D.
- ☐ 2 Friend of patient called M.D.
- ☐ 3 Another physician
- ☐ 4 Hospice R.N.
- ☐ 5 Hospital R.N.
- ☐ 6 Nursing home/Assisted-living staff
- ☐ 7 Funeral home
- ☐ 8 Medical Examiner
- ☐ 9 Other (specify):_____

14. Did the patient take the lethal dose of medication according to the prescription directions?

- ☐ 1 Yes
- ☐ 2 No

If no: Please list the medications the patient took (other than those reported in item 10), the dosages, and the reason for not following the prescription directions.

_____

_____

_____

- ☐ 9 Unknown

15. Were there any complications after the ingestion of the lethal dose of medication, for example, vomiting, seizures, or regaining consciousness?

☐ 1 Yes (please describe):

_____

_____

_____

☐ 2 No
☐ 9 Unknown

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

☐ 1 Yes (please describe):

_____

_____

_____

☐ 2 No
☐ 9 Unknown

17. What was the time between ingestion of the lethal dose of medication and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

18. What was the time between ingestion of the lethal dose of medication and death?

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

Do you have any observations on why the patient lived for more than six hours after ingesting the medication?

_____

_____

_____

_____

19. *Immediately* prior to ingestion of the lethal dose of medication, what was the patient's mobility? (ECOG scale)

☐ 0 Fully active, no restrictions on pre-disease performance.
☐ 1 Restricted in strenuous activity, but ambulatory and able to carry out work.
☐ 2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.
☐ 3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.
☐ 4 Completely disabled, no self-care, totally confined to bed or chair.
☐ 9 Unknown

20. Where did the patient ingest the 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

21. At the time of ingestion of the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, other (specify) _____
- ☐ 9 Unknown

22. What is your medical specialty? (*Check all that apply.*)

- ☐ 1 Family Practice
- ☐ 2 Internal Medicine
- ☐ 3 Oncology
- ☐ 4 Other (specify) _____

23. How many years have you been in practice, not including any training periods, such as residency or fellowship?

Years: _____

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

_____

_____

_____

Original Signature of Physician: _____

FOR OFFICIAL USE ONLY

CASE ID NUMBER: ☐ DWDA ☐ ILLNESS ☐ OTHER

PHYSICIAN ID NUMBER:

Washington State Department of Health

PHARMACY DISPENSING RECORD

MAIL FORM TO: State Registrar, Center for Health Statistics, P.O. Box 47856, Olympia, WA 98504-7856

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	

B	PHYSICIAN INFORMATION	
	NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: ( ) —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	

C	DISPENSING HEALTH CARE PROVIDER INFORMATION	
	NAME (LAST, FIRST, M.I.) AND TITLE:	TELEPHONE NUMBER: ( ) —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	DATE OF THIS REPORT:

D	MEDICATIONS DISPENSED			
	MEDICATIONS	**QUANTITY**	**DATE PRESCRIBED**	**DATE DISPENSED**
	#1			
	#2			
	#3			
	#4			

E	SIGNATURE		
	DISPENSING HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE	TELEPHONE NUMBER ( ) —	DATE