

ATTENDING PHYSICIAN'S COMPLIANCE FORM

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

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. RCW 70.245.150 requires the attending physician to complete and mail this form within thirty (30) calendar days of writing a prescription for a lethal dose of medication. **Important note: RCW 70.245.150 does not permit forms to be submitted electronically to the Department of Health.** 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 contact DeathwithDignity@doh.wa.gov.

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

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

C ACTION TAKEN TO COMPLY WITH LAW	
1. FIRST ORAL REQUEST FOR MEDICATION TO END LIFE	DATE:
<i>Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)</i>	
<input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination the patient has six months or less to live. <input type="checkbox"/> 3. Determination that patient is competent*. <input type="checkbox"/> 4. Determination that patient is a Washington state resident**. <input type="checkbox"/> 5. Determination that patient is acting voluntarily. <input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of: <ul style="list-style-type: none"> <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with taking the medication to be prescribed; and <input type="checkbox"/> d) The potential result of taking the medication to be prescribed; and <input type="checkbox"/> e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control. 	
<i>Indicate compliance by checking the boxes.</i>	DATE:
<input type="checkbox"/> 1. Patient informed of his or her right to rescind the request at any time. <input type="checkbox"/> 2. Patient recommended informing next of kin. <input type="checkbox"/> 3. Patient counseled about the importance of having another person present when the patient takes the medication(s). <input type="checkbox"/> 4. Patient counseled about the importance of not taking the medication in a public place.	
2. SECOND ORAL REQUEST <i>(Must be made 15 days or more after the first oral request.)</i>	
<i>Indicate compliance by checking the boxes.</i>	DATE:
<input type="checkbox"/> 1. Second oral request for medication to end life. <input type="checkbox"/> 2. Patient informed of the right to rescind the request at any time.	
3. PATIENT'S WRITTEN REQUEST	
<input type="checkbox"/> Written request for medication to end life received. Please attach request. <i>(No less than 48 hours shall elapse between the written request and writing the prescription.)</i>	DATE:

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

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) :			
<input type="checkbox"/> 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.			
<input type="checkbox"/> 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:	
<input type="checkbox"/> Dispensed medication directly. Date:	
<input type="checkbox"/> Contacted pharmacist and delivered prescription personally or by mail to the pharmacist. <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Pharmacy Name: City: Telephone number: </div>	
Immediately prior to writing the prescription, the patient was fully informed of: <i>(check boxes)</i>	
<input type="checkbox"/> (a) his or her medical diagnosis; <input type="checkbox"/> (b) his or her prognosis; <input type="checkbox"/> (c) the potential risks associated with taking the medication to be prescribed; <input type="checkbox"/> (d) the probable result of taking the medication to be prescribed; <input type="checkbox"/> (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:

G COMMENTS (Please include any issues encountered by you or the patient with the process to comply with requirements)	

* "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.

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.