Clear Form

Washington State Department of Health

DOH 422-065 May 2022

CONSULTING PHYSICIAN'S COMPLIANCE FORM

Deliver this form to the referring/prescribing physician who will mail it to:
State Registrar, Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Washington Death with Dignity Act requires attending 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 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:
PATIENT RECORD NUMBER:	

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 (STREET, CITY, STATE AND ZIP CODE):		
EMAIL ADDRESS:		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.