ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH
	PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B	ATTENDING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

C	CONSULTING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

D	ELIGIBILITY DETERMINATION
	1. TERMINAL DISEASE
	2. CHECK BOXES FOR COMPLIANCE: ☐ 1. Determination that the patient has a terminal disease. ☐ 2. Determination that patient is a resident of California. ☐ 3. Determination that patient has the capacity to make medical decisions** ☐ 4. Determination that patient is acting voluntarily. ☐ 5. Determination of capacity by mental health specialist, if necessary. ☐ 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 ingesting the requested aid-in-dying drug; ☐ d) The probable result of ingesting the aid-in-dying drug; ☐ e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

E	ADDITIONAL COMPLIANCE REQUIREMENTS

- ☐ 1. Counseled patient about the importance of all of the following:
- ☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
- ☐ b) Having another person present when he or she ingests the aid-in-dying drug;
- ☐ c) Not ingesting the aid-in-dying drug in a public place;
- ☐ d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
- ☐ e) Participating in a hospice program or palliative care program.
- ☐ 2. Informed patient of right to rescind request (1st time)
- ☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion
- ☐ 5. First oral request for aid-in-dying: _____/_____/_____ Attending physician initials:_____
- ☐ 6. Second oral request for aid-in-dying:_____/_____/_____ Attending physician initials:_____
- ☐ 7. Written request submitted: _____/_____/_____ Attending physician initials:_____
- ☐ 8. Offered patient right to rescind (2nd time)

F	PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

- ☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

Mental health specialist's information, if applicable:

MENTAL HEALTH SPECIALIST NAME
MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER
MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G	MEDICATION PRESCRIBED	
	PHARMACIST NAME	TELEPHONE NUMBER ( ) —

1. Aid-in-dying medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
2. Antiemetic medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically
4. Date medication was prescribed:_____/_____/_____

	X	PHYSICIAN'S SIGNATURE	DATE
		NAME (PLEASE PRINT)	

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

CONSULTING PHYSICIAN COMPLIANCE FORM

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

B	ATTENDING PHYSICIAN	
	ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —

C	CONSULTING PHYSICIAN'S REPORT	
	1. TERMINAL DISEASE	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 that patient has the mental capacity to make medical decisions.**
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. 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 drug to be prescribed; and
- ☐ d) The potential result of taking the drug to be prescribed; and
- ☐ e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

D	PATIENT'S MENTAL STATUS		
	Check one of the following **(required)**:		
	☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.		
	☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.		
	☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder		
	MENTAL HEALTH SPECIALIST'S NAME	TELEPHONE NUMBER ( ) —	DATE

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

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____/_____/_____

Patient name: _____

Attending physician name: _____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

- ☐ **Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
  Attending physician signature:_____
- ☐ **Underlying illness** → There is no need to complete the rest of the form. Please sign below.
  Attending physician signature:_____
- ☐ **Other** → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign
  Please specify:
  _____
  _____

Attending physician signature:_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

- ☐ The attending physician was present at the time of death.

→ The attending physician must complete this form in its entirety and sign Part A and Part B.

- ☐ The attending physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.

- ☐ Neither the attending physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?

- ☐ Yes
- ☐ No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

- ☐ Yes, another physician
- ☐ Yes, a trained health-care provider/volunteer
- ☐ No
- ☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?

- ☐ Yes
- ☐ No

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

- ☐ Yes, another physician or licensed health care provider
- ☐ No
- ☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?
_____/_____/_____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
_____/_____/_____ (month/day/year) ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

- ☐ Private home
- ☐ Assisted-living residence
- ☐ Nursing home
- ☐ Acute care hospital in-patient
- ☐ In-patient hospice resident
- ☐ Other (specify)_____
- ☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?
Minutes_____ and/or Hours_____ ☐Unknown

7. What was the time between lethal medication ingestion and death?
Minutes_____ and/or Hours_____ ☐Unknown

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- ☐ Yes- vomiting, emesis
- ☐ Yes-regained consciousness
- ☐ No Complications
- ☐ Other- Please describe:_____
- ☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- ☐ Yes- Please describe:_____
- ☐ No
- ☐ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician:_____

Signature of Licensed Health Care Provider: _____

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? _____/_____/_____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)

- ☐ Medicare
- ☐ Medi-cal
- ☐ Covered California
- ☐ V.A.
- ☐ Private Insurance
- ☐ No insurance
- ☐ Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug Please check "yes," "no," or "Don't' know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about . . .

- **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**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Persistent and uncontrollable pain and suffering**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **A loss of Dignity**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Other concerns** (specify): _____

Signature of attending physician: _____

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____,
am an adult of sound mind and a resident of the State of California.

I am suffering from _____,
which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

_____ I have informed one or more members of 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 withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:_____ **Dated:**_____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) is personally known to us or has provided proof of identity;
(b) voluntarily signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

Witness 1:_____ **Date:**_____

Witness 2:_____ **Date:**_____

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a 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.

REQUEST FOR AN AID-IN-DYING - INTERPRETER DECLARATION

I, _____, am fluent in English and _____.
NAME OF INTERPRETER — TARGET LANGUAGE

On _____ at approximately _____,
DATE — TIME

I read the "Request for an Aid-In-Dying Drug to End My Life" to

_____ in _____.
NAME OF PATIENT/QUALIFIED INDIVIDUAL — TARGET LANGUAGE

Mr./Ms. _____
NAME OF PATIENT/QUALIFIED INDIVIDUAL

affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and _____
TARGET LANGUAGE

and further declare under penalty of perjury that the foregoing is true and correct.

Executed at _____, _____, _____
CITY — COUNTY — STATE

on this _____ of _____, _____.
DAY OF MONTH — MONTH — YEAR

_____
INTERPRETER SIGNATURE

_____
INTERPRETER PRINTED NAME

_____ _____ _____ _____
INTERPRETER STREET ADDRESS — CITY — STATE — ZIP CODE

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____,
am an adult of sound mind and a resident of the State of California.

I am suffering from _____,
which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of 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.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:_____

Dated:_____

Time:_____