## CONSULTING PHYSICIAN’S COMPLIANCE FORM

**ORS 127.800 - ORS 127.897**

Deliver this form to the attending/prescribing physician who will mail it to:
**Oregon State Public Health Division, Center for Health Statistics,**
**P.O. Box 14050, Portland, OR 97293-0050**

### A. PATIENT INFORMATION

<table>
<thead>
<tr>
<th>PATIENT’S NAME (LAST, FIRST, M.I.)</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

### B. REFERRING/PRESCRIBING PHYSICIAN

<table>
<thead>
<tr>
<th>REFERRING/PRESCRIBING PHYSICIAN’S NAME (LAST, FIRST, M.I.)</th>
<th>TELEPHONE NUMBER ( ) —</th>
</tr>
</thead>
</table>

### C. CONSULTANT’S REPORT

1. **MEDICAL DIAGNOSIS**

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 6 months or less to live.
- [ ] 3. Determination that patient is capable.**
- [ ] 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 ORS 127.825.
- [ ] 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.

<table>
<thead>
<tr>
<th>PSYCHIATRIC CONSULTANT’S NAME</th>
<th>TELEPHONE NUMBER ( ) —</th>
<th>DATE</th>
</tr>
</thead>
</table>

### E. CONSULTANT’S INFORMATION

- **PHYSICIAN’S SIGNATURE**

- **NAME (PLEASE PRINT)**

- **MAILING ADDRESS**

- **CITY, STATE AND ZIP CODE**

- **TELEPHONE NUMBER ( ) —**

**Note:** This form is revised periodically. To assure that you are using the most current version, please refer to:

Rev. 11/06