

## Oregon Death with Dignity Act Attending Physician Follow-up Form

Dear Physician:

The Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication to complete this follow-up form within **10 calendar days** of a patient's death, whether from ingestion of the lethal dose of medications obtained under the Act or from any other cause.

**For DHS to accept this form, it must be signed by the Attending (Prescribing) Physician, whether or not he or she was present at the patient's time of death.**

This form should be mailed to the address on the last page. *All information is kept strictly confidential.* If you have any questions, call: 971-673-1150.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Patient's Name:** \_\_\_\_\_

**Name of Attending (Prescribing) Physician:** \_\_\_\_\_

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Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please contact the family or patient's representative.**

**1 Death with Dignity** (lethal medication) → *Please sign below and go to page 2.*

Attending (Prescribing) Physician Signature \_\_\_\_\_

**2 Underlying illness** → *There is no need to complete the rest of the form. Please sign below.*

Attending (Prescribing) Physician Signature \_\_\_\_\_

**3 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 (Prescribing) Physician Signature \_\_\_\_\_

**PART A and PART B should only be completed if the patient died from ingesting the lethal dose of medication.**

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

- The Attending (Prescribing) Physician was present at the time of death.

→ *The Attending (Prescribing) Physician must complete this form in its entirety and sign Part A and Part B.*

- The Attending (Prescribing) 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 (Prescribing) Physician must complete and sign Part B of the form.*

- Neither the Attending (Prescribing) Physician nor another licensed health care provider was present at the time of death.

→ *Part A may be left blank. The Attending (Prescribing) Physician must complete and sign Part B of the form.*

**PART A: To be completed and signed by the Attending (Prescribing) 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 lethal dose of medication?

1 Yes

2 No

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

1 Yes, another physician

2 Yes, a trained health-care provider/volunteer

3 No

9 Unknown

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

1 Yes

2 No

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

1 Yes, another physician or licensed health care provider

3 No

9 Unknown

3. On what day did the patient consume the lethal dose of medication?

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  9 Unknown

4. On what day did the patient die after consuming the lethal dose of medication?

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  9 Unknown

5. Where did the patient ingest the lethal dose of 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

6. What was the time between lethal medication ingestion and unconsciousness?

Minutes: \_\_\_\_\_ or Hours: \_\_\_\_\_  Unknown

7. What was the time between lethal medication ingestion and death?

Minutes: \_\_\_\_\_ or Hours: \_\_\_\_\_  Unknown

*If the patient lived longer than six hours, are there any observations on why the patient lived for more than six hours after ingesting the lethal dose of medication?* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**8.** Were there any complications that occurred after the patient took the lethal dose of medication? For example: vomiting, seizures, or regaining consciousness?

- 1 Yes – vomiting, emesis
- 2 Yes – seizures
- 3 Yes – regained consciousness
- 4 No complications
- 5 Other – please describe: \_\_\_\_\_  
\_\_\_\_\_
- 9 Unknown \_\_\_\_\_

**9.** Was the Emergency Medical System activated for any reason after ingesting the lethal dose of medication?

- 1 Yes - please describe: \_\_\_\_\_  
\_\_\_\_\_
- 2 No
- 9 Unknown

**10.** At the time of ingesting the lethal dose of medication, was the patient receiving hospice care?

- 1 Yes
- 2 No, refused care
- 3 No, never offered care
- 4 No, other (specify) \_\_\_\_\_
- 9 Unknown

**11.** And lastly, are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

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Signature of Attending (Prescribing) Physician present at time of death:

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Name of Licensed Health Care Provider present at time of death if not Attending (Prescribing) Physician:

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Signature of Licensed Health Care Provider

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**PART B : To be completed and signed by the Attending (Prescribing) Physician**

12. On what date did the attending physician begin caring for this patient?

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)

13. On what date was the prescription written for the lethal dose of medication?

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)

14. When the patient initially requested a prescription for a lethal dose of medication, was the patient receiving hospice care?

- 1 Yes
- 2 No, refused care
- 3 No, never offered care
- 4 No, other (specify) \_\_\_\_\_
- 9 Unknown

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

16. What type of health-care coverage did the patient have for their underlying illness?

*(Check all that apply.)*

- 1 Medicare
- 2 Oregon Health Plan/Medicaid
- 3 Military/CHAMPUS
- 4 V.A.
- 5 Indian Health Service
- 6 Private insurance (e.g., Kaiser, Blue Cross, Medigap)
- 7 No insurance
- 8 Had insurance, don't know type
- 9 Unknown

**17.** Are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

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Signature of Attending (Prescribing) Physician:

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Please mail this document to:

Center for Health Statistics

Oregon Health Authority

P. O. Box 14050

Portland, OR 97293-0050

Copies of this form are available at:

<http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/pasforms.aspx>