

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

PLEASE PRINT

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

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. <i>(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 6 months or less to live.	
<input type="checkbox"/> 3. Determination that patient is capable.**	
<input type="checkbox"/> 4. Determination that patient is acting voluntarily.	
5. Determination that patient has made his/her decision after being fully informed of:	
<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.	
Comments:	

D PATIENT'S MENTAL STATUS		
Check one of the following <i>(required)</i> :		
<input type="checkbox"/> 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.		
<input type="checkbox"/> I have referred the patient to the provider listed below for evaluation and consulting 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 SIGNATURE	DATE
	NAME (PLEASE PRINT)	
MAILING ADDRESS		
CITY, STATE AND ZIP CODE		TELEPHONE NUMBER () —

** "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating, if those persons are available.

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

<http://www.healthoregon.org/dwd>