

**ATTENDING PHYSICIAN'S COMPLIANCE FORM**

ORS 127.800 - ORS 127.897

MAIL FORM 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:
MEDICAL DIAGNOSIS	

B PHYSICIAN INFORMATION	
NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER
MAILING ADDRESS	
CITY, STATE AND ZIP CODE	

C ACTION TAKEN TO COMPLY WITH LAW	
<b>1. FIRST ORAL REQUEST FOR MEDICATION</b>	
<i>Indicate compliance by checking the boxes</i>	DATE
<input type="checkbox"/> 1. Determination that the patient has a terminal disease <input type="checkbox"/> 2. Determination the patient has six months or less to live (If less than 15 days, check here: <input type="checkbox"/> - see footnote 3.) <input type="checkbox"/> 3. Determination that patient is capable <sup>1</sup> <input type="checkbox"/> 4. Determination that patient is an Oregon resident <sup>2</sup> <input type="checkbox"/> 5. Determination that patient is acting voluntarily <input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of: a) His or her medical diagnosis b) His or her prognosis c) The potential risks associated with taking the medication to be prescribed d) The potential result of taking the medication to be prescribed e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control	
<i>Indicate compliance by checking the boxes.</i>	DATE:
<input type="checkbox"/> 1. Patient informed of his or her right to rescind the request at any time <input type="checkbox"/> 2. Patient recommended to inform next of kin <input type="checkbox"/> 3. Patient counseled about the importance of having another person present when the patient takes the medication(s) <input type="checkbox"/> 4. Patient counseled about the importance of not taking the medication in a public place	
Comments:	
<b>2. SECOND ORAL REQUEST FOR MEDICATION</b>	
<i>Must be 15 days or more after the first oral request unless patient is exempt<sup>3</sup></i>	DATE:
<i>Indicate compliance by checking the boxes.</i>	
<input type="checkbox"/> 1. Patient made second oral request for medication to end life <input type="checkbox"/> 2. Patient informed of the right to rescind the request at any time	
Comments:	

SEND A COPY OF THIS FORM TO THE OREGON STATE PUBLIC HEALTH DIVISION  
**ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)**

**PATIENT INFORMATION**

PATIENT'S NAME	DATE OF BIRTH
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**C ACTION TAKEN TO COMPLY WITH THE LAW – continued**

<b>3.</b>	<b>PATIENT'S WRITTEN REQUEST</b>	
	Written request for medication to end life received (Please attach request) <i>(Must be at least 48 hours before writing the prescription unless patient is exempt<sup>3</sup>)</i>	DATE
	Comments:	

**D MEDICAL CONSULTATION (Attach consultant's form.)**

Medical consultation and second opinion requested from:		
MEDICAL CONSULTANT'S NAME	TELEPHONE NUMBER	DATE

**E PSYCHIATRIC/PSYCHOLOGICAL EVALUATION**

<i>Check one of the following (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, <b>and attached the consultant's form.</b>		
PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER	DATE

**F MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT**

*(To be prescribed no sooner than 48 hours after patient's written request has been signed unless patient is exempt<sup>3</sup>)*

Lethal medication prescribed and dose	DATE PRESCRIBED
<i>Please check one of the following:</i>	
<input type="checkbox"/> Dispensed medication directly → Date _____	
<input type="checkbox"/> Contacted pharmacist and delivered prescription personally or by mail to the pharmacist	
Pharmacy Name:	City: Phone #:
Immediately prior to writing the prescription, the patient was fully informed of: (check boxes)	
<input type="checkbox"/> 1. His or her medical diagnosis	
<input type="checkbox"/> 2. His or her prognosis	
<input type="checkbox"/> 3. The potential risks associated with taking the medication to be prescribed	
<input type="checkbox"/> 4. The probable result of taking the medication to be prescribed	
<input type="checkbox"/> 5. The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control	
To the best of my knowledge, all of the requirements under the Death with Dignity Act have been met.	
<b>X</b>	PHYSICIAN'S SIGNATURE
	DATE

1. "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.

2. Factors demonstrating residency include, but are not limited to: 1) possession of an Oregon driver's license, 2) registration to vote in Oregon, 3) evidence that a person leases/owns property in Oregon, or 4) filing of an Oregon tax return for the most recent tax year.

3. A patient is exempt from any waiting period that exceeds his/her life expectancy. The Attending Physician must have a medically confirmed certification of the imminence of the patient's death in the patient's medical record if any waiting periods are not completed.

**IT IS THE ATTENDING PHYSICIAN'S RESPONSIBILITY** to send the following documents to the Public Health Division:

1) Patient's written request; 2) Consulting physician's report; and 3) Psychiatric evaluation referral report (if performed).

This form is revised periodically. To assure that you are using the most current version, please refer to <http://www.healthoregon.org/dwd>