



Patient Choice at End of Life — Physician Reporting Form

Mail form to:
Vermont Department of Health, Vital Records
P.O. Box 70, Burlington, VT 05402-0070

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 (with area code)
MAILING ADDRESS	
CITY, STATE AND ZIP CODE	


C ACTION TAKEN TO COMPLY WITH LAW	
1. FIRST ORAL REQUEST	
<input type="checkbox"/> The patient made an oral request for medication to be self-administered for the purpose of hastening the patient's death.	DATE
Comments:	
2. SECOND ORAL REQUEST (Must be made 15 days or more after the first oral request.)	
Indicate compliance by checking the boxes.	DATE
<input type="checkbox"/> 1. Second oral request for medication to hasten death.	
<input type="checkbox"/> 2. Patient informed of the right to rescind the request at any time.	
Comments:	
3. WRITTEN REQUEST	
<input type="checkbox"/> The patient made a written request for medication to hasten death.	DATE
Comments:	

continued

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(continued)

4. PHYSICIAN DETERMINATIONS
<p>Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)</p> <p>1. Determined that the patient:</p> <p><input type="checkbox"/> a) is suffering with a terminal condition;*</p> <p><input type="checkbox"/> b) is capable;**</p> <p><input type="checkbox"/> c) is making an informed decision;</p> <p><input type="checkbox"/> d) has made a voluntary request for medication to hasten his or her death;</p> <p><input type="checkbox"/> e) is at least 18 years old and a Vermont state resident.***</p> <p>2. Informed the patient in person, both verbally and in writing, of all the following:</p> <p><input type="checkbox"/> a) the patient's medical diagnosis;</p> <p><input type="checkbox"/> b) the patient's prognosis, including an acknowledgement that the physician's prediction of the patient's life expectancy is an estimate based on the physician's best medical judgment;</p> <p><input type="checkbox"/> c) the range of treatment options appropriate for the patient and the patient's diagnosis;</p> <p><input type="checkbox"/> d) if the patient was not enrolled in hospice care, all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;</p> <p><input type="checkbox"/> e) the range of possible results, including potential risks associated with taking the medication to be prescribed; and</p> <p><input type="checkbox"/> f) the probable result of taking the medication to be prescribed.</p> <p><input type="checkbox"/> 3. Referred the patient to a second physician for medical confirmation.</p> <p><input type="checkbox"/> 4. Verified that the patient did not have impaired judgment based on my evaluation or as the result of a referral of the patient to a psychiatric or psychological clinician.</p>

D MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT		
To be prescribed no sooner than 48 hours after the last of the following:		
1. Patient's written request was signed;	DATE	
2. The patient's second oral request;	DATE	
3. Offering the patient the opportunity to rescind the request.	DATE	
To the best of my knowledge, all of the requirements under the Patient Choice at End of Life Act have been met.		
	PHYSICIAN'S SIGNATURE	DATE

If comments in any section exceed the space provided, please use an attached page. Supplemental comments should be identified using the appropriate alphanumeric notation (e.g., C3).

* "Terminal condition" means an incurable and irreversible disease that would, within reasonable medical judgment, result in death within six months.

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

*** Factors demonstrating residency include, but are not limited to: 1) Possession of a Vermont driver's license; 2) Registration to vote in Vermont; 3) Evidence that a person leases/owns property in Vermont; or 4) Filing of a Vermont tax return for the most recent tax year. Only the attending physician is required to affirm Vermont residency.

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