For OHA use only:
Case ID: _____ - _____

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 OHA 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.

Mail completed form to:

Oregon Center for Health Statistics
P.O. Box 14050
Portland, OR 97293-0050

All information is kept strictly confidential. If you have any questions, call 971-673-1150.

Date: _____

Patient's Name: _____

Attending (Prescribing) Physician: _____

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** → ***Please sign below and stop. There is no need to complete the rest of the form. Submit page 1 only.***

Attending (Prescribing) Physician Signature: _____

☐ 3. **Other** → ***Please specify the circumstances of the patient's death, sign below, and stop. There is no need to complete the rest of the form. Submit page 1 only.***

Please specify:

Attending (Prescribing) Physician Signature: _____

Patient:

Check the appropriate box below and follow the instructions for completing PART A and PART B of this form.

PART A covers the circumstances of the patient's ingestion and death.
PART B covers the patient's status and possible reasons for utilizing the DWDA.

☐ **1. The Attending (Prescribing) Physician was present at the time of death.**

→ *The Attending (Prescribing) Physician must complete and sign Part A and Part B.*

☐ **2. The Attending (Prescribing) Physician was not present at the time of death, but another licensed health care provider or volunteer was present.**

→ *The licensed provider or volunteer may complete and sign Part A of this form. The Attending (Prescribing) Physician must complete and sign Part B of the form.*

Licensed provider or volunteer contact information:

Name:	
Phone:	
Affiliation:	

☐ **3. *Neither the Attending (Prescribing) Physician nor another licensed health care provider or volunteer 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 and PART B should only be completed if the patient died from ingesting the lethal dose of medication.

PART A: Completed and signed by the health care provider or volunteer who was present at death.	**Patient:**

1. Was the attending physician at the patient's bedside when the patient took the lethal dose of medication?
   - ☐ 1. Yes
   - ☐ 2. No
     - → 1a. **If no:** Was another physician, licensed health care provider, or volunteer present when the patient took the lethal dose of medication?
       - ☐ 1. Yes, another physician
       - ☐ 2. Yes, another licensed health care provider
       - ☐ 3. Yes, a volunteer
       - ☐ 4. No
       - ☐ 9. Unknown

2. Was the attending physician at the patient's bedside at the time of death?
   - ☐ 1. Yes
   - ☐ 2. No
     - → 2a. **If no:** Was another physician, licensed health care provider, or volunteer present at the patient's time of death?
       - ☐ 1. Yes, another physician
       - ☐ 2. Yes, another licensed health care provider
       - ☐ 3. Yes, a volunteer
       - ☐ 4. No
       - ☐ 9. Unknown

3. On what date did the patient consume the lethal dose of medication?
   _____ / _____ / _____ (month/day/year) ☐ Unknown

4. On what date did the patient die after consuming the lethal dose of medication?
   _____ / _____ / _____ (month/day/year) ☐ 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

PART A: Completed and signed by the health care provider or volunteer who was present at death.	**Patient:**

7. What was the time between lethal medication ingestion and death?
   Minutes: _____ or Hours: _____ ☐ Unknown

   → 7a. **If longer than six hours:** Are there any observations on why the patient lived for more than six hours after ingesting the lethal dose of mediation?

8. Were there any complications that occurred after the patient took the lethal dose of medication?
   - ☐ 1. Yes, vomiting
   - ☐ 2. Yes, seizures
   - ☐ 3. Yes, regained consciousness
   - ☐ 4. No complications
   - ☐ 5. Other – describe: _____
   - ☐ 9. Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of medication?
   - ☐ 1. Yes – 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 – describe: _____
    - ☐ 9. Unknown

11. Please provide any other comments, feedback, or insights you would like to share with us.

Person completing PART A of this form:

Signature:		Date:	

Check one:		
	☐	Patient's Attending (Prescribing) Physician
	☐	A physician (other than the patient's Attending Physician)
	☐	Another licensed health care provider
	☐	Volunteer

PART B: Completed and signed by the Attending (Prescribing) Physician.	**Patient:**

12. Date attending physician begin caring for patient: _____ / _____ / _____ (month/day/year)

13. Date DWDA prescription written: _____ / _____ / _____ (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 – describe: _____
    - ☐ 9. Unknown

15. Several possible concerns contributing to the patient's decision to request a prescription for lethal medication are shown below. Please check yes, no, or unknown to indicate whether you believe each concern contributed to the patient's request.

A concern about…	**Yes**	**No**	**Unk**
...the financial cost of treating or prolonging his or her terminal condition?	Y	N	U
...the physical or emotional burden on family, friends, or caregivers?	Y	N	U
...his or her terminal condition representing a steady loss of autonomy?	Y	N	U
...the decreasing ability to participate in activities that made life enjoyable?	Y	N	U
...the loss of control of bodily functions, such as incontinence and vomiting?	Y	N	U
...inadequate pain control at the end of life?	Y	N	U
...a loss of dignity?	Y	N	U

16. What type(s) 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)
    - ☐ 7. No insurance
    - ☐ 8. Had insurance, don't know type
    - ☐ 9. Unknown

17. Please provide any other comments, feedback, or insights you would like to share with us.

Signature of Attending (Prescribing) Physician:

Signature:		Date:	