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Commissioner

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Attending Physician End-of-Life Reporting Form

PLEASE PRINT

A	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
	MEDICAL DIAGNOSIS AND PROGNOSIS	
B	**PHYSICIAN INFORMATION**	
	NAME (LAST, FIRST, MI)	TELEPHONE
	MAILING ADDRESS	
	CITY, STATE, ZIP	
	CONSULTING PHYSICIAN NAME	TELEPHONE
C	**ACTION TAKEN TO COMPLY WITH LAW**	
	1. FIRST ORAL REQUEST	
	☐ The patient made an oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	
	2. SECOND ORAL REQUEST (Must be made 15 days or more after the first oral request.)	
	Indicate compliance by checking the boxes. ☐ 1. The patient made a second oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner. ☐ 2. Attending physician has offered the patient an opportunity to rescind the request.	DATE
	Comments:	
	3. WRITTEN REQUEST (Must be made 15 days or more after the first oral request.)	
	☐ The patient made a written request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE
	Comments:	

4. ATTENDING PHYSICIAN DETERMINATIONS AND ACTIONS

Indicate compliance by checking the boxes.

I have determined that the patient:

- ☐ is at least 18 years of age;
- ☐ is suffering with a terminal disease;
- ☐ is competent; and
- ☐ has made a voluntary request for medication to self-administer for the purpose of ending the patient's life in a humane and dignified manner.

I have requested that the patient:

- ☐ demonstrate he/she is a Maine state resident, and I am satisfied the patient is a Maine state resident.

To ensure the patient is making an informed decision, I have informed the patient of the following:

- ☐ the patient's medical diagnosis;
- ☐ the patient's prognosis;
- ☐ the potential risks associated with taking the medication to be prescribed;
- ☐ the probable result of taking the medication to be prescribed; and
- ☐ the feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I have taken the additional following steps:

- ☐ Referred the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;
- ☐ Confirmed that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is making an informed decision;
- ☐ Verified that the patient, based on my evaluation or following a referral for counseling, is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement;
- ☐ Recommended that the patient notify the patient's next of kin;
- ☐ Counseled the patient about the importance of having another person present when the patient takes the medication prescribed, and counseled the patient about not taking the medication prescribed in a public place;
- ☐ Informed the patient that the patient has the opportunity to rescind the request at any time and in any manner; and
- ☐ Verified immediately before writing a prescription for life-ending medication that the patient is making an informed decision.

D MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

To be prescribed no sooner than **48 hours after** the date of the written request.

MEDICATION PRESCRIBED AND DOSAGE:	DATE PRESCRIBED

NAME OF PHARMACIST AND ADDRESS (if applicable)

E MEDICAL COVERAGE/PATIENT INSURANCE

What is the principal source of medical coverage for the patient?

- ☐ a) Private Insurance
- ☐ b) Government Payor includes Medicare, Indian Health Service, or CHAMPUS
- ☐ c) Mainecare or Medicaid
- ☐ d) Self Pay
- ☐ e) None
- ☐ f) Unknown

To the best of my knowledge, all of the requirements of the Death with Dignity Act, 22 M.R.S. chapter 418, 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). **Retain the original form in the patient's medical record. Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics within 30 days of writing the prescription.**