Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

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Consulting Physician End-of-Life Care

PLEASE PRINT

A	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
B	**REFERRING/ATTENDING PHYSICIAN INFORMATION**	
	NAME	TELEPHONE NUMBER
C	**CONSULTING PHYSICIAN DETERMINATIONS**	
	I examined the above-named patient on _____ (date) at _____ (time). I have also reviewed the patient's relevant medical records. By checking below, I confirm the attending physician's diagnosis that the patient is suffering from a terminal disease, specifically _____ (list diagnosis), and verify that the patient is competent, is acting voluntarily, and had made an informed decision: ☐ a) diagnosis that patient is suffering from a terminal disease; ☐ b) patient is competent; ☐ c) patient is making an informed decision; ☐ d) patient is acting voluntarily in his/her request for medication to end his/her life in a humane and dignified manner.	
D	**CONSULTING PHYSICIAN'S INFORMATION**	
	NAME (please print)	LICENSE NUMBER
	MAILING ADDRESS	
	CITY, STATE, ZIP	TELEPHONE NUMBER
	PHYSICIAN'S SIGNATURE	DATE

To the consulting physician: Provide the completed form to the attending physician.
To the attending physician: Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics. Retain the original in the patient's medical record.