Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
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End-of-Life Closure Form

Dear Physician:

Pursuant to the Department of Health and Human Services' authority to collect information under **the Death with Dignity Act**, 22 M.R.S. chapter 418, the Department requires physicians who write a prescription for medication for a patient to self-administer for the purpose of ending the patient's life in a humane and dignified manner to complete this follow-up form within **30 calendar days** of a patient's death, if known to the physician or **or 6 months of writing the prescription**.

For the Department of Health and Human Services to accept this form, it must be signed by the Attending Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the attention of the State Registrar at: 220 Capitol Street, 11 State House Station, Augusta, Maine, 04330. *All information is kept strictly confidential.* If you have any questions, call: 207-287-5459.

Patient's Name:_____**DOB:**_____/_____/_____

Name of Attending Physician**:** _____

Prescription Record

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 mark the form indicating that.**

- ☐ 1. **Patient Choice** (self-administered medication)
- ☐ 2. **Underlying illness**
- ☐ 3. **Unknown**
- ☐ 4. **Other** (please specify):

_____

How was the unused medication disposed of? If unknown, please indicate the same.

_____

Attending Physician Signature: _____

Date:_____/_____/_____