VERMONT

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	STATE OF RESIDENCE

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	
	☐ 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. ☐ 1. Second oral request for medication to hasten death. ☐ 2. Patient informed of the right to rescind the request at any time.	DATE
	Comments:	
	3. WRITTEN REQUEST	
	☐ The patient made a written request for medication to hasten death.	DATE
	Comments:	

continued

Patient Choice At End Of Life — Physician Reporting Form

(continued)

4. PHYSICIAN DETERMINATIONS

Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)

1. Determined that the patient:

- ☐ a) is suffering with a terminal condition;*
- ☐ b) is capable;**
- ☐ c) is making an informed decision;
- ☐ d) has made a voluntary request for medication to hasten his or her death;
- ☐ e) is at least 18 years old.

2. Informed the patient in person, both verbally and in writing, of all the following:

- ☐ a) the patient's medical diagnosis;
- ☐ 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;
- ☐ c) the range of treatment options appropriate for the patient and the patient's diagnosis;
- ☐ d) if the patient was not enrolled in hospice care, all feasible ende ofe life services, including palliative care, comfort care, hospice care, and pain control;
- ☐ e) the range of possible results, including potential risks associated with taking the medication to be prescribed; and
- ☐ f) the probable result of taking the medication to be prescribed.

3. ☐ Referred the patient to a second physician for medical confirmation.

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.

D **MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT**

1. Patient's written request was signed;	DATE
2. The patients 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.

X	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.

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