END-OF-LIFE OPTION ACT ATTENDING PHYSICIAN FOLLOW-UP FORM

The End-of-Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health 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 or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____

Patient Name: _____

Attending Physician Name: _____

CAUSE OF DEATH

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause, such as terminal sedation or ceasing to eat or drink?

- ❑ Aid-in-dying drug (lethal dose) — Please sign below and go to page 2.

  Attending physician signature: _____

- ❑ Underlying illness — There is no need to complete the rest of the form. Please sign below.

  Attending physician signature: _____

- ❑ Other — There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign.

  Please specify: _____

Attending physician signature: _____

(over)

Part A and Part B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

- ❑ The attending physician was present at the time of death.

  The attending physician must complete this form in its entirety and sign Part A and Part B.

- ❑ The attending physician was not present at the time of death, but another licensed health care provider was present.

  The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of this form.

- ❑ Neither the attending physician nor another licensed health care provider was present at the time of death.

  Part A may be left blank. The attending physician must complete and sign Part B of this form.

PART A. TO BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN OR ANOTHER LICENSED HEALTH CARE PROVIDER PRESENT AT DEATH

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?
   - ❑ Yes
   - ❑ No

     If no: was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

     - ❑ Yes, another physician
     - ❑ Yes, a trained health care provider/volunteer
     - ❑ No
     - ❑ Unknown
2. Was the attending physician at the patient's bedside at the time of death?
   - ❑ Yes
   - ❑ No

     If no: was another physician or licensed health care provider present at the patient's time of death?

     - ❑ Yes, another physician or licensed health care provider
     - ❑ No
     - ❑ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying drug?

   _____ ❑ Unknown

   (month/day/year)

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?

   _____ ❑ Unknown

   (month/day/year)

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

   ❑ Private home

   ❑ Assisted-living residence

   ❑ Nursing home

   ❑ Acute care hospital in-patient

   ❑ In-patient hospice resident

   ❑ Other (specify) _____

   ❑ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?

   Minutes _____ and/or Hours _____ ❑ Unknown

7. What was the time between lethal medication ingestion and death?

   Minutes _____ and/or Hours _____ ❑ Unknown

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

   ❑ Yes — vomiting, emesis

   ❑ Yes — regained consciousness

   ❑ No complications

   ❑ Other — please describe: _____

   ❑ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

   ❑ Yes — please describe: _____

   ❑ No

   ❑ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?
    - ❑ Yes
    - ❑ No, refused care
    - ❑ No, other (specify) _____

SIGNATURE

_____

Signature of attending physician present and time of death

_____

Name of licensed health care provider present at time of death if not attending physician

_____

Signature of licensed health care provider

PART B. TO BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN

1. On what date was the prescription written for the aid-in-dying drug? _____
2. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?
    - ❑ Yes
    - ❑ No, refused care
    - ❑ No, other (specify) _____
3. What type of health care coverage did the patient have for their underlying illness? *(Check all that apply)*
    - ❑ Medicare
    - ❑ Medi-Cal
    - ❑ Covered California
    - ❑ V.A.
    - ❑ Private insurance
    - ❑ No insurance
    - ❑ Had insurance, do not know type

4. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug. Please check "Yes," "No," or "Don't know," depending on whether or not you believe that concern contributed to their request. *(Please check as many boxes as you think may apply.)*

   a. His or her terminal condition representing a steady loss of autonomy

      ❑ Yes

      ❑ No

      ❑ Don't Know

   b. The decreasing ability to participate in activities that made life enjoyable

      ❑ Yes

      ❑ No

      ❑ Don't Know

   c. The loss of control of bodily functions

      ❑ Yes

      ❑ No

      ❑ Don't Know

   d. Persistent and uncontrollable pain and suffering

      ❑ Yes

      ❑ No

      ❑ Don't Know

   e. A loss of dignity

      ❑ Yes

      ❑ No

      ❑ Don't Know

   f. Other concerns (specify): _____

SIGNATURE

_____

Signature of attending physician