END-OF-LIFE OPTION ACT ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

PATIENT INFORMATION

Patient's Name: _____
(last) *(first)* *(M.I.)*

Date of Birth: _____

Patient's Address: _____
(street)

_____
(city) *(zip code)*

ATTENDING PHYSICIAN INFORMATION

Physician's Name: _____
(last) *(first)* *(M.I.)*

Telephone Number: _____

Mailing Address: _____
(street)

_____
(city) *(zip code)*

Physician's License Number: _____

CONSULTING PHYSICIAN INFORMATION

Physician's Name: _____
(last) *(first)* *(M.I.)*

Telephone Number: _____

Mailing Address: _____
(street)

_____
(city) *(zip code)*

Physician's License Number: _____

ELIGIBILITY DETERMINATION

1. Terminal Disease

_____

2. Check boxes for compliance:
   - ❑ 1. Determination that the patient has a terminal disease.
   - ❑ 2. Determination that the patient is a resident of California.
   - ❑ 3. Determination that the patient has the capacity to make medical decisions.[1]
   - ❑ 4. Determination that patient is acting voluntarily.
   - ❑ 5. Determination of capacity by mental health specialist, if necessary.
   - ❑ 6. Determination that patient has made his/her decision after being fully informed of:
     - ❑ a. His or her medical diagnosis; and
     - ❑ b. His or her prognosis; and
     - ❑ c. The potential risks associated with ingesting the requested aid-in-dying drug;
     - ❑ d. The probable result of ingesting the aid-in-dying drug;
     - ❑ e. The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

ADDITIONAL COMPLIANCE REQUIREMENTS

- ❑ 1. Counseled patient about the importance of all of the following:
  - ❑ a. Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
  - ❑ b. Having another person present when he or she ingests the aid-in-dying drug;
  - ❑ c. Not ingesting the aid-in-dying drug in a public place;
  - ❑ d. Notifying the next of kin of his or her request for an aid-in-dying drug (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
  - ❑ e. Participating in a hospice program or palliative care program.
- ❑ 2. Informed patient of right to rescind request (1st time).
- ❑ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ❑ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion.

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1 **"Capacity to make medical decisions"** means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand the significant benefits, risks, and alternatives, and the ability to make and communicate an infiormed decision to health care providers.

- ❑ 5. First oral request for aid-in-dying: _____ Attending Physician Initials: _____
  (date)
- ❑ 6. Second oral request for aid-in-dying: _____ Attending Physician Initials: _____
  (date)
- ❑ 7. Written request submitted: _____ Attending Physician Initials: _____
  (date)
- ❑ 8. Offered patient right to rescind (2nd time).

PATIENT'S MENTAL STATUS

Check one of the following (required):

- ❑ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ❑ I have referred the patient to the mental health specialist[2] listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ❑ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder.

MENTAL HEALTH SPECIALIST'S INFORMATION, IF APPLICABLE:

_____

Name

_____

Title and License Number

_____

Address (street, city, zip code)

2 **"Mental Health Specialist"** means a psychiatrist or a licensed psychologist.

MEDICATION PRESCRIBED

Pharmacist Name: _____

Telephone Number: _____

1. Aid-in-dying medication prescribed:
   - ❑ a. Name: _____
   - ❑ b. Dosage: _____
2. Antiemetic medication prescribed:
   - ❑ a. Name: _____
   - ❑ b. Dosage: _____
3. Method prescription was delivered:
   - ❑ a. In person
   - ❑ b. By mail
   - ❑ c. Electronically
4. Date medication was prescribed: _____

SIGNATURE

_____ _____

Physician Signature Date

_____

Name (Please Print)