

**ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM**

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| A PATIENT INFORMATION | |
| PATIENT'S NAME (LAST, FIRST, M.I.) | DATE OF BIRTH |
| PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE) | |
| | |
| B ATTENDING PHYSICIAN INFORMATION | |
| PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER () - |
| MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| PHYSICIAN'S LICENSE NUMBER | |
| | |
| C CONSULTING PHYSICIAN INFORMATION | |
| PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER () - |
| MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| PHYSICIAN'S LICENSE NUMBER | |
| | |
| D ELIGIBILITY DETERMINATION | |
| TERMINAL DISEASE | |
| CHECK BOXES FOR COMPLIANCE: | |
| <input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination that patient is a resident of California. <input type="checkbox"/> 3. Determination that patient has the capacity to make medical decisions** <input type="checkbox"/> 4. Determination that patient is acting voluntarily. <input type="checkbox"/> 5. Determination of capacity by mental health specialist, if necessary. <input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of: <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with ingesting the requested aid-in-dying drug; <input type="checkbox"/> d) The probable result of ingesting the aid-in-dying drug; <input type="checkbox"/> e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it | |

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| E | ADDITIONAL COMPLIANCE REQUIREMENTS |
| <input type="checkbox"/> 1. counseled patient about the importance of all of the following: <input type="checkbox"/> a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it; <input type="checkbox"/> b) Having another person present when he or she ingests the aid-in-dying drug; <input type="checkbox"/> c) Not ingesting the aid-in-dying drug in a public place; <input type="checkbox"/> 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 <input type="checkbox"/> e) Participating in a hospice program or palliative care program. <input type="checkbox"/> 2. Informed patient of right to rescind request (1 st time) <input type="checkbox"/> 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control. <input type="checkbox"/> 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion <input type="checkbox"/> 5. First oral request for aid-in-dying: ____/____/____ Attending physician initials: _____ <input type="checkbox"/> 6. Second oral request for aid-in-dying: ____/____/____ Attending physician initials: _____ <input type="checkbox"/> 7. Written request submitted: ____/____/____ Attending physician initials: _____ <input type="checkbox"/> 8. Offered patient right to rescind (2 nd time) | |

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| F | PATIENT'S MENTAL STATUS |
| Check one of the following (required): | |
| <input type="checkbox"/> 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. <input type="checkbox"/> I have referred the patient to the mental health specialist****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. <input type="checkbox"/> 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: | |
| MENTAL HEALTH SPECIALIST NAME | |
| MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER | |
| MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE) | |

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| G | MEDICATION PRESCRIBED | |
|---|------------------------------|-------------------------------------|
| PHARMACIST NAME | | TELEPHONE NUMBER () - |
| 1. Aid-in-dying medication prescribed: <input type="checkbox"/> a. Name: <input type="checkbox"/> b. Dosage: 2. Antiemetic medication prescribed: <input type="checkbox"/> a. Name: <input type="checkbox"/> b. Dosage: 3. Method prescription was delivered: <input type="checkbox"/> a. In person <input type="checkbox"/> b. By mail <input type="checkbox"/> c. Electronically 4. Date medication was prescribed: ____/____/_____ | | |

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|  | PHYSICIAN'S SIGNATURE | DATE |
| NAME (PLEASE PRINT) | | |

** "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 its significant benefits, risks, and alternatives, and the ability to make informed decisions.

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