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 his 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:_____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another

☐ **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.
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:_____

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 the 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 the form.

ATTENDING PHYSICIAN FOLLOW-UP 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 a 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?
   ___/___/_____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
   ___/___/_____ (month/day/year) ☐ Unknown

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 of attending physician present at 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

12. On what date was the prescription written for the aid-in-dying drug?
___/___/_____ (month/day/year)

13. 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) _____

14. What type of health-care coverage did the patient have for their underlying illness?(Check all that apply.)

☐ Medicare
☐ Medi-Cal
☐ Covered California
☐ VA
☐ Private Insurance
☐ No insurance
☐ Had insurance, don't know type

15. 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 concern about. . .

o **His or her terminal condition representing a steady loss of autonomy**
☐ Yes
☐ No
☐ Don't Know

o **The decreasing ability to participate in activities that made life enjoyable**
☐ Yes
☐ No
☐ Don't Know

o **The loss of control of bodily functions**
☐ Yes
☐ No
☐ Don't Know

o P**ersistent and uncontrollable pain and suffering**
☐ Yes
☐ No
☐ Don't Know

o **A loss of Dignity**
☐ Yes
☐ No
☐ Don't Know

o **Other concerns** (specify): _____

Signature of attending physician: _____