ATTENDING PHYSICIAN'S CHECKLIST FOR DEATH WITH DIGNITY

This document was created by End of Life Washington to assist you in completing the Death with Dignity Act (DWDA) requirements, but is not part of the required DWDA Department of Health paperwork. If this document is not helpful to you, please disregard it.

Patient Name: ____

- ❑ First oral request for Death with Dignity — Date ____________
- ❑ Determined that patient has terminal illness — Date ____________
- ❑ Verified that patient is resident of Washington — Date ____________
- ❑ Evaluated patient's judgment and competency — Date ____________
- ❑ Referred for psych consult, if needed — Date ____________
- ❑ Received psych consultant's compliance form, if needed — Date ____________
- ❑ Informed patient of right to rescind – 1st time — Date ____________
- ❑ Why patient has requested Death with Dignity:

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- ❑ Inquired about financial and social issues — Date__________
- ❑ Asked about possible coercion — Date __________
- ❑ Discussed alternatives to aid in dying — Date __________
- ❑ Recommended patient notify next-of-kin — Date __________

Informed Patient of the Following:

- ❑ Diagnosis — Date __________
- ❑ Prognosis — Date __________
- ❑ Risk of ingesting medication — Date __________
- ❑ Result — Date __________
- ❑ Alternatives — Date __________

- ❑ 2nd opinion by Dr. ________________________________ — Date __________
- ❑ Received Consulting Physician's Compliance Form — Date __________
- ❑ Received Written Request for Medication — Date __________
- ❑ Second oral request (not less than 15 days after 1st) — Date __________
- ❑ Informed patient of right to rescind – 2nd time — Date __________
- ❑ Counseled patient to take medication in a private setting — Date __________
- ❑ Counseled patient to take medication with someone present — Date __________
- ❑ Called pharmacist — Date __________
- ❑ Rx for anti-emetic: ______________________________ ___mg — Date __________
  ______________________________ ___mg — Date __________

- ❑ Rx for barbiturate: ______________________________ ___ mg — Date __________
- ❑ Rx for other: ______________________________ ___ mg — Date __________
- ❑ Complete and return forms to DOH — Date __________

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