



CONSULTING PHYSICIAN'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:
 State Registrar, Center for Health Statistics,
 P.O. Box 47856, Olympia, WA 98504-7856

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B	REFERRING/PRESCRIBING PHYSICIAN	
	REFERRING/PRESCRIBING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () —

C	CONSULTANT'S REPORT	
	1. MEDICAL DIAGNOSIS	DATE OF EXAMINATION(S)
	2. Check boxes for compliance. <i>(Both the attending and consulting physicians must make these determinations.)</i> <input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination the patient has 6 months or less to live. <input type="checkbox"/> 3. Determination that patient is competent.* <input type="checkbox"/> 4. Determination that patient is acting voluntarily. 5. 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 taking the medication to be prescribed; and <input type="checkbox"/> d. The potential result of taking the medication to be prescribed; and <input type="checkbox"/> e. The feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control. Comments:	

D	PATIENT'S MENTAL STATUS		
	Check one of the following (required) : <input type="checkbox"/> I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with chapter 70.245 RCW. <input type="checkbox"/> I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.		
	PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER () —	DATE

E	CONSULTANT'S INFORMATION		
	X	PHYSICIAN'S ORIGINAL SIGNATURE	DATE
		NAME (PLEASE PRINT)	
	MAILING ADDRESS		
	CITY, STATE AND ZIP CODE		TELEPHONE NUMBER () —

* "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.