Clear Form

Washington State Department of Health

DOH 422-068 May 2022

ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

MAIL FORM TO:
State Registrar, Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Washington Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication under the Act to report to the Department of Health information that documents compliance with the law. RCW 70.245.150 requires the attending physician to complete and mail this form within thirty (30) calendar days of a patient's ingestion of a lethal dose of medication obtained pursuant to the act or death from any other cause, whichever comes first. ***Important note: RCW 70.245.150 does not permit forms to be submitted electronically to the Department of Health.*** If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All individual information will be kept strictly confidential. Aggregate information will be provided on an annual basis. If you have questions about these instructions, please contact DeathwithDignity@doh.wa.gov.

PATIENT INFORMATION		
	PATIENT'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH (mm/dd/yyyy):
	PATIENT RECORD NUMBER:	DATE OF DEATH (mm/dd/yyyy):

1. What was the patient's underlying illness?

Check all that apply:	Specify type:
☐ Cancer	
☐ Respiratory	
☐ Neurodegenerative	
☐ Cardiac Illness	
☐ Other	

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

☐ 1. Medicare	☐ 6. Private insurance
☐ 2. Medicaid	☐ 7. No insurance
☐ 3. Military/CHAMPUS	☐ 8. Had insurance, don't know type
☐ 4. V.A.	☐ 9. Unknown
☐ 5. Indian Health Service	

3. When the patient initially requested a prescription for the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1. Yes
- ☐ 2. No, refused care
- ☐ 3. No, other (specify): _____
- ☐ 9. Unknown

4. At the time of ingestion of the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1. Patient did not ingest medication
- ☐ 2. Yes
- ☐ 3. No, refused care
- ☐ 4. No, other (specify): _____
- ☐ 9. Unknown

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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5. Seven possible concerns that may have contributed to the patient's decision to request a prescription for the lethal dose of medication are shown below. The patient expressed the following concerns (check all that apply).

A concern about:

- ☐ …the financial cost of treating or prolonging his or her terminal condition.
- ☐ …the physical or emotional burden on family, friends, or caregivers.
- ☐ …his or her terminal condition representing a steady loss of autonomy.
- ☐ …the decreasing ability to participate in activities that made life enjoyable.
- ☐ …the loss of control of bodily functions, such as incontinence and vomiting.
- ☐ …inadequate pain control at the end of life.
- ☐ …a loss of dignity.

6. What medication was prescribed and what was the dosage?

MEDICATIONS (check all that apply):	DOSAGE:	DATE PRESCRIBED:
☐ Diazepam		
☐ Amitriptyline		
☐ Digoxin		
☐ Morphine		
☐ Metoclopramide		
☐ Propranolol		
☐ Haloperidol		
☐ Other (specify):		

7. If known, on what date was the lethal dose of medication dispensed to the patient?

_____ (mm/dd/yyyy) ☐ Not Dispensed ☐ Unknown

8. Did the patient ingest the lethal dose of medication?

- ☐ 1. Yes
- ☐ 2. No (skip to question 17)
- ☐ 9. Unknown (skip to question 17)

9. Were you with the patient when they took the lethal dose of medication?

- ☐ 1. Yes
- ☐ 2. No, did not offer to be present at the time of ingestion
- ☐ 3. No, offered to be present, but the patient declined
- ☐ 4. No, another health care provider was present
- ☐ 5. No, someone else was present (specify): _____
- ☐ 9. Unknown

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10. Were you with the patient at the time of death?

- ☐ 1. Yes
- ☐ 2. No, did not offer to be present at the time of death
- ☐ 3. No, offered to be present, but the patient declined
- ☐ 4. No, another health care provider was present
- ☐ 5. No, someone else was present (specify): _____
- ☐ 9. Unknown

11. Did the patient take the lethal dose of medication according to the prescription directions?

- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Unknown

12. Were there any complications after the ingestion of the lethal dose of medication, for example, vomiting, seizures, or regaining consciousness?

- ☐ 1. Yes (please describe):

- ☐ 2. No
- ☐ 9. Unknown

13. Was the Emergency Medical System activated for any reason after the ingestion of the lethal dose of medication?

- ☐ 1. Yes (please describe):

- ☐ 2. No
- ☐ 9. Unknown

14. What was the time between ingestion of the lethal dose of medication and unconsciousness?

Minutes: _____ or Hours: _____ ☐ Unknown

15. What was the time between ingestion of the lethal dose of medication and death?

Minutes: _____ or Hours: _____ ☐ Unknown

If the patient lived longer than six hours:

Do you have any observations on why the patient lived for more than six hours after ingesting the medication?

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16. Where did the patient ingest the medication?

- ☐ 1. Private home
- ☐ 2. Assisted-living residence
- ☐ 3. Nursing home
- ☐ 4. Acute care hospital in-patient
- ☐ 5. In-patient hospice resident
- ☐ 6. Other (specify): _____
- ☐ 9. Unknown

17. And lastly, do you have any comments on this follow-up questionnaire, or any other comments or insights you would like to share with us?

Original Signature of Physician: _____

Physician's Name: _____

Date: _____ (mm/dd/yyyy)