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Governor

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## Consulting Physician End-of-Life Care

**PLEASE PRINT**

<b>A PATIENT INFORMATION</b>	
PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
<b>B REFERRING/ATTENDING PHYSICIAN INFORMATION</b>	
NAME	TELEPHONE NUMBER
<b>C CONSULTING PHYSICIAN DETERMINATIONS</b>	
<p>I examined the above-named patient on _____ (date) at _____ (time). I have also reviewed the patient's relevant medical records.</p> <p>By checking below, I confirm the attending physician's diagnosis that the patient is suffering from a terminal disease, specifically _____ (list diagnosis), and verify that the patient is competent, is acting voluntarily, and had made an informed decision:</p> <p><input type="checkbox"/> a) diagnosis that patient is suffering from a terminal disease;</p> <p><input type="checkbox"/> b) patient is competent;</p> <p><input type="checkbox"/> c) patient is making an informed decision;</p> <p><input type="checkbox"/> d) patient is acting voluntarily in his/her request for medication to end his/her life in a humane and dignified manner.</p>	
<b>D CONSULTING PHYSICIAN'S INFORMATION</b>	
NAME (please print)	LICENSE NUMBER
MAILING ADDRESS	
CITY, STATE, ZIP	TELEPHONE NUMBER
PHYSICIAN'S SIGNATURE	DATE

**To the consulting physician:** Provide the completed form to the attending physician.

**To the attending physician:** Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics. Retain the original in the patient's medical record.