Washington State Department of HEALTH

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Instructions for the Attending Qualified Medical Provider's After Death Reporting Form

The Washington Death with Dignity Act (chapter 70.245 RCW) allows a qualified patient with a terminal illness with six months or less to live to request medication that the patient may self-administer to end their life. If you have questions about these instructions, contact DeathwithDignity@doh.wa.gov.

Attending Qualified Medical Provider Requirements

The Death with Dignity Act only provides immunity from civil and criminal liability and disciplinary action for good faith compliance. Upon the death of the qualified patient, as the attending qualified medical provider, you must:

- Certify the patient's death certificate within 5 calendar days from the date of death.
- Submit this completed form **within 30 calendar days after the date of death**.

Send the completed forms to the Department of Health.

- **Online through REDCap: https://redcap.link/DeathWithDignity.**
- By fax: 360-200-7408
- By mail: Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Department of Health will contact you if the forms are missing information. We keep all information strictly confidential and only release aggregate information on an annual basis.

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Attending Qualified Medical Provider's After Death Reporting Form

The Attending Qualified Medical Provider must fill out and send the completed form to the Department of Health **within 30 calendar days** after the patient's death. Unless otherwise specified, fill out all text fields and check all boxes to indicate you completed the task.

A. Patient Information

Patient Name (Last, First, M.I.): _____ Date of Birth: _____

Patient Record Number: _____ Date of Death: _____

B. Questions About the Patient

1. What was the patient's underlying illness? (Check all that apply.)

- ☐ Cancer — Specify: _____
- ☐ Respiratory — Specify: _____
- ☐ Neurodegenerative — Specify: _____
- ☐ Cardiac Illness — Specify: _____
- ☐ Other — Specify: _____

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

- ☐ Medicare
- ☐ Medicaid
- ☐ Military/CHAMPUS
- ☐ V.A.
- ☐ Indian Health Service
- ☐ Private insurance
- ☐ No insurance
- ☐ Had insurance, don't know type
- ☐ Unknown

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

- ☐ Yes
- ☐ No, refused care
- ☐ No, other — Specify: _____
- ☐ Unknown

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

- ☐ Patient did not ingest medication
- ☐ Yes
- ☐ No, refused care
- ☐ No, other — Specify: _____
- ☐ Unknown

Patient Name (Last, First, M.I.): _____ Date of Birth: _____

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. (Check all that apply.)

The patient expressed the following concerns:

- ☐ …the financial cost of treating or prolonging the patient's terminal condition.
- ☐ …the physical or emotional burden on family, friends, or caregivers.
- ☐ …the patient's 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 did you prescribe? (Check all that apply.)

Prescription Date: _____

Check all medications prescribed.

- ☐ DDMP2 - Diazepam, Digoxin, Morphine, and Propranolol
- ☐ DDMA - Diazepam, Digoxin, Morphine, and Amitriptyline
- ☐ DDMAPh - Diazepam, Digoxin, Morphine, Amitriptyline, and Phenobarbital
- ☐ Metoclopramide
- ☐ Haloperidol
- ☐ Odansetron
- ☐ Other (specify): _____

7. On what date was the lethal dose of medication dispensed to the patient?

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

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

☐ Yes ☐ No (skip to question 17) ☐ Unknown (skip to question 17

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

- ☐ Yes
- ☐ No, did not offer to be present at the time of ingestion.
- ☐ No, offered to be present, but the patient declined.
- ☐ No, another health care provider was present.
- ☐ No, someone else was present. Specify: _____
- ☐ Unknown

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

☐ Yes
☐ No, did not offer to be present at the time of death.
☐ No, offered to be present, but the patient declined.
☐ No, another health care provider was present.
☐ No, someone else was present. Specify: _____
☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes (please describe):

☐ No
☐ Unknown

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

☐ Yes (please describe):

☐ No
☐ 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?

16. Where did the patient ingest the medication?

- ☐ Private home
- ☐ Assisted-living residence
- ☐ Nursing home
- ☐ Acute care hospital in-patient
- ☐ In-patient hospice resident
- ☐ Other Specify: _____
- ☐ 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?

C. Attending Qualified Medical Provider Confirmation

To the best of my knowledge, all of the requirements under the Washington Death with Dignity Act have been met.

Provider Signature: _____ Date: _____

Name (Last, First, M.I.): _____ Title: _____

Mailing Address (Street, City, State, And Zip Code): _____

Email Address: _____ Phone Number: _____