

Compassion & Choices of Oregon

Physician's Checklist to use for the Medical Record

PO Box 6404, Portland, OR 97228

Phone: 503-525-1956

E-mail: info@compassionoforegon.org

All state documents and instructions are online at www.compassionoforegon.org

Patient Name: _____

- First oral request for aid-in-dying Date_____
- Determined that patient has terminal illness Date_____
- Verified patient is adult resident of Oregon Date_____
- Evaluated patient's judgment and capability Date_____
- Referred for mental health evaluation, if needed Date_____
- Received **Psychiatrist/Psychologist Consultant Compliance Form**, if needed Date_____
- Informed patient of right to rescind - 1st time Date_____
- Why patient has requested aid-in-dying: _____ Date_____

- Inquired about financial and social issues, including coercion Date_____
- Recommended patient notify next-of-kin Date_____
- Informed patient of following:
 - Diagnosis
 - Prognosis
 - Risk of ingesting medication
 - Result of ingesting medication
 - Alternatives to hastening death with medication Date_____

- Consultation by _____ Date_____
- Received **Consulting Physician's Compliance Form** Date_____
- Received written **Request for Medication Form** Date_____
- Second oral request (at least 15 days after 1st request). Verify patient is making informed decision and restate right to rescind. Date_____

- Counseled patient to take medication with someone in private setting Date_____

- Called pharmacist _____ Date_____

- Rx for antiemetic: _____ mg Date_____

<input type="checkbox"/>	Rx for antiemetic: _____	_____mg	Date_____
<input type="checkbox"/>	Rx for barbiturate: _____	_____mg	Date_____
<input type="checkbox"/>	(Rx must be written at least 48 hours after DATE of written Request.) Mail or deliver prescriptions to pharmacy.		Date_____
<input type="checkbox"/>	Completed DHS form, copied & mailed all 3 forms to DHS within 7 days of writing Rx.		Date_____
<input type="checkbox"/>	Physician signature _____		Date_____