Patient Choice at End of Life — Consulting Physician Reporting Form

Deliver form to the attending/prescribing physician who will mail it to:

Vermont Department of Health, Vital Records
P.O. Box 70, Burlington, VT 05402-0070

PLEASE PRINT

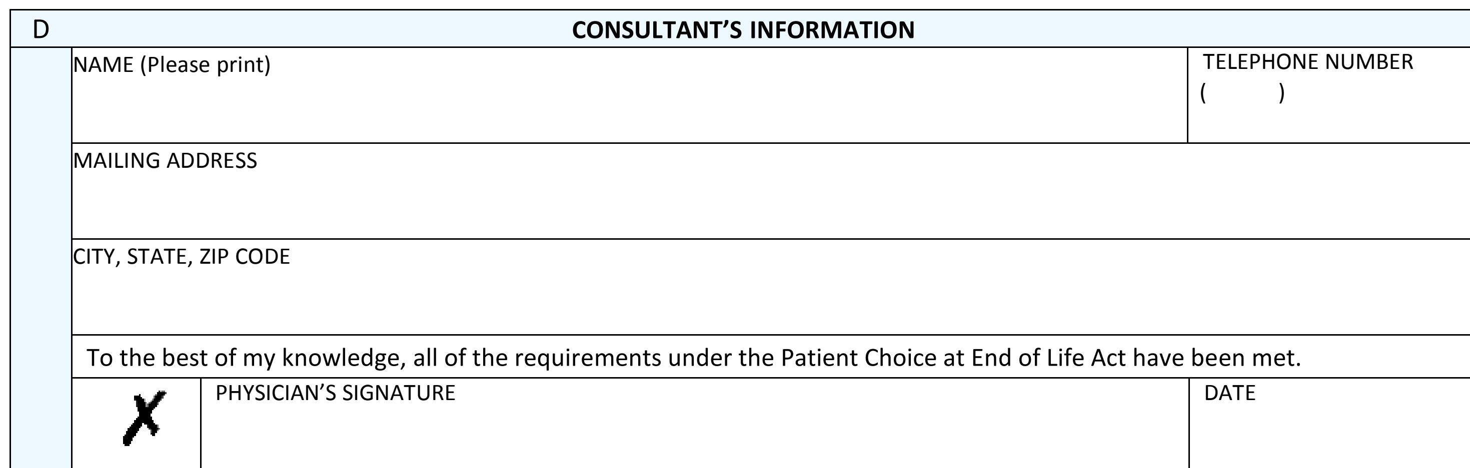
A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B	REFERRING/PRESCRIBING PHYSICIAN INFORMATION	
	NAME	TELEPHONE NUMBER ( )

C	CONSULTING PHYSICIAN DETERMINATIONS
	Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)

Confirmed the:

- ☐ a) diagnosis and prognosis;
- ☐ b) patient is capable;*
- ☐ c) patient is making an informed decision;
- ☐ d) patient has made a voluntary request for medication to hasten his or her death.



D	CONSULTANT'S INFORMATION		
	NAME (Please print)		TELEPHONE NUMBER ( )
	MAILING ADDRESS		
	CITY, STATE, ZIP CODE		
	To the best of my knowledge, all of the requirements under the Patient Choice at End of Life Act have been met.		
	✗	PHYSICIAN'S SIGNATURE	DATE

* "Capable" means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available.

07/02/2013