MARSHALL MEDICAL CENTER
It's about you

POLICY TITLE: End of Life Option Act	
DISTRIBUTION: MMC employees, physicians, allied health professionals, volunteers, ministries.	**PAGE:** 1 of 6
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AUTHOR/OWNER: Lisa Kissel, Compliance & Privacy Officer	**APPROVED BY:** Lisa Kissel, Compliance & Privacy Officer Siri Nelson, CEO MMC Board Audit Compliance Committee

SCOPE:

This policy is limited to self-administered life-ending drugs and does not preclude or replace other existing policies, including but not limited to, Withdrawing or Foregoing Life Sustaining Treatment, Pain Management, Advance Directives/POLST, DNR, or the other end-of-life care services Marshall Medical Center (MMC) provides.

POLICY STATEMENT:

To describe MMC's position regarding the California End of Life Option Act ("the Act") and to provide guidance to physicians opting in and providing care to their patients who express interest in ending their life under the Act.

VALUES CONTEXT:

The end-of-life care Marshall Medical Center (MMC) provides is grounded in the values of respecting the sacredness of life, providing compassionate care to dying and vulnerable persons, and respecting the integrity of health care providers. MMC believes in compassionate, end-of- life care. MMC will not abandon dying patients or their families and is committed to provide appropriate support for dying persons and their families through the final stages of life by supporting patient self-determination through the use of advance directives, offering hospice, palliative and other supportive care, and providing effective pain and symptom management and other social, spiritual, and pastoral care support and services.

DEFINITIONS:

Aid-in-dying drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease.

Attending Physician: The physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

Capacity to make medical decisions: is defined as, in the opinion of an individual's Attending Physician, consulting physician, psychiatrist, or psychologist, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.

PROCEDURE AND/OR GUIDELINE:

1. MMC's Board of Directors approved to allow only physicians on its medical staff, who wish to prescribe aid-in-dying drug to their terminally ill patients, may do so outside MMC facilities including but not limited to the hospital, clinics, and all outpatient departments/locations. MMC will not provide aid-in-dying drug to hospitalized patients nor provide the drugs to be taken in a clinic or other outpatient setting. MMC caregivers will still provide other requested palliative care services to patients and their family, regardless of the patient's stated interest in exercising his/ her rights under the Act.
2. If a physician participates in the Act, he/she must immediately notify MMC's Chief Nursing Officer. It is the physician's responsibility to ensure that correct procedures are followed and the correct documentation is completed in accordance with the Act and this policy.
3. Any member of a patient care team may respond to questions about the Act from a patient and family with openness and compassion. Providers should seek to learn the meaning behind the patient's questions and help the patient understand the range of available options that MMC offers such as pain control, palliative and hospice care. MMC's goal is to help patients make informed decisions about end-of-life care. However, any request for aid-in-dying planning must be referred to the patients Attending Physician.

GUIDANCE FOR PROVIDERS WHO WISH TO PROVIDE SERVICES UNDER THE ACT

A. Patient Qualifications

1. The patient must make the request for information about an aid-in-dying drug prescription. No one else can make the request on behalf of the patient such as an agent under a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decision maker.
2. The patient's request must be voluntary, not coerced, as determined by the Attending Physician.
3. Patients must have a DNR order and/or POLST filed in his/her medical record.
4. Patients must meet the following qualifications:
    a) Must be 18 years of age and have capacity to make informed decisions.
    b) Must have a terminal diagnosis confirmed by two physicians (attending and consulting) which is incurable and irreversible with a life expectancy of six months or less.
    c) Must be a California resident. Residency can be established through one of the following:
        1) Valid California driver's license or ID card;
        2) Registration to vote in California;
        3) Evidence that patient owns, rents or leases property in California;

4) The most recent filing of a California tax return;

d) Must not be suffering from mental illness interfering with decision making capacity.

e) Must have the physical and mental ability to self-administer the drug without help.

f) Must make two verbal requests separated by a minimum of 48 hours apart and one written request on a special form, *Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner.* (See Attachment A).

g) Must be willing to meet with a mental health professional if requested by the attending or consulting physician.

B. Attending Physician Responsibilities

1. The Attending Physician shall directly, and not through a designee, receive the patients request and ensure that the date of the request is documented in the patient's medical record. An oral request documented in the patient's medical record is not to be disregarded by the Attending Physician solely because it was received by a prior Attending Physician or an Attending Physician who has chosen not to participate in the Act.
2. Attending Physicians who are unable or unwilling to support the patients request for aid-in-dying drugs are required to:
   a) Inform the patient they do not participate in the End of Life Option Act
   b) Document the patient's date of request in their medical record
   c) Transfer the patient's relevant medical records upon request to a physician who is willing to act as a prescriber.
3. Make the initial determination about whether the patient is qualified under the Act.
4. Ensures that the patient's request is made voluntarily; meets separately with the patient to ensure no coercion is involved. Makes it clear that the patient may withdraw or rescind the request at any time.
5. Confirms that the patient has made an informed decision by discussing all of the following:
   a) His or her medical diagnosis and prognosis.
   b) The potential risks associated with ingesting the requested drug.
   c) The probable result of ingesting the drug.
   d) The possibility that he or she may choose to obtain the drug but not take it.
   e) The feasible alternatives or additional treatment options such as comfort care, hospice care, palliative care and pain control.
6. Counsels the patient about having another person present when the drug is taken; notifying next of kin, though not required; keeping the drug in a safe place until use; and participating in hospice care.
7. Makes referrals to an independent consulting physician qualified by specialty or experience, as required by the Act and to a mental health specialist (psychiatrist or psychologist) for evaluation if there are indications of a mental disorder.
8. Verifies before writing the prescription that the patient still wants an aid-in-dying drug and is making an informed decision. The physician has a non-delegable obligation to offer the patient the opportunity to withdraw or rescind the request prior to writing the prescription.

9. Confirms that all requirements are met and all appropriate steps are carried out in accordance with the Act prior to writing a prescription.
10. Completes the *End of Life Option Act Attending Physician Checklist and Compliance Form (*See Attachment B*)* and fulfills the documentation and reporting requirements outlined under Section F below.
11. Provides the patient the *Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner.* (See Attachment A) and instructs the patient about completing it.
12. Within 30 calendar days following the patient's death from ingesting the aid-in-dying drug, or any other cause, whichever comes first, the Attending Physician must complete the *End of Life Option Act Attending Physician Follow-Up Form* (See Attachment D).

C. Consulting Physician Responsibilities

1. Confirms the diagnosis and prognosis, in writing, after examining the patient and relevant medical records.
2. Determines the patient's mental capacity and voluntary decision.
3. If there are indications of a mental disorder, refers the individual for a mental health evaluation.
4. Fulfills the documentation and repo1ting requirements outlined under Section F below.
5. Completes the *End of Life Option Act Consulting Physician Compliance Form (*See Attachment C).

Note: The attending, consulting and mental health specialist may not be a witness to the patient's written request and cannot be related to the patient by blood, marriage, registered domestic partnership, or adoption or entitled to a portion of the estate.

D. Patient Responsibilities

a) The patient must make two verbal requests, a minimum of 48 hours apart, to his/her attending physician.

b) The patient must make a written request that meets all of the following conditions to be valid:

   a) Use the California-required form, *Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner* (See Attachment A).

   b) Signs and dates the form in the presence of two adult witnesses. Only one of the two witnesses may be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the patient's estate upon death.

c) The patient shall not ingest the drug on any MMC property or public place as defined by law.

E. Use of Interpreters

1. If the requesting patient has limited English language proficiency, a qualified interpreter must be used to interpret the conversations and consultations between the patient and his/her attending and consulting physicians. The interpreter must meet the standards endorsed by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by CDPH.
2. The patient's written request form is provided in English and includes an interpreter's declaration, signed under penalty of perjury, that affirms that the interpreter read the *Request for an Aid-in-Dying Drugs to*

End My Life in a Humane and Dignified Manner (See Attachment A) form to the patient in the patient's target language.

3. The interpreter must not be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the estate.

F. Prescribing or Delivering the Aid-in-Dying Drug

1. After the attending physician has met all his/her responsibilities, the drug may be delivered in any of the following ways:
   a) Dispensing the drug directly to the patient;
   b) With the patient's **written** consent, contacting a pharmacist and delivering the written prescription personally, by mail, or electronically to the pharmacist.

   Handing the patient a written prescription to take to a pharmacy **is not permitted**.

G. Documentation and Reporting Requirements

1. Medical Record. All of the following must be documented in the patient's medical record:
   a) All oral and written requests for the aid-in-dying drug.
   b) The attending and consulting physicians' diagnosis and prognosis; their determinations of the patient's capacity to make informed medical decisions; the voluntary nature of the request; and their determinations that the patient does/does not meet the requirements of a qualified individual under the Act.
   c) The mental health specialist's assessment, if applicable.
   d) The attending physician's offer to the patient to withdraw or rescind the request at the time of the second oral request.
   e) The attending physician's note indicating that all requirements under Sections B and C above have been met, including the drug prescribed.
2. Death Certificate. The Act states that death resulting from the self-administration of an aid-in-dying drug is not suicide, assisted suicide, homicide or elder abuse. However, it is silent regarding the cause of death that should be listed on the death certificate. Physicians should list the cause(s) of death that they feel is most accurate.
3. Reporting to the California Department of Public Health (CDPH). Within 30 calendar days of writing a prescription, the attending physician must submit the following:
   a) A copy of the patient's written request, the Attending Physician Checklist & Compliance Form (Attachment B), and the Consulting Physician Compliance Form (Attachment C).
   b) Within 30 calendar days following the patient's death from ingesting the aid-in-dying drug, or any other cause, whichever comes first, the Attending Physician Follow-Up Form (See Attachment D).
   c) The forms are sent to CDPH at the following address:

      California Department of Public Health Public Health Policy and Research Branch
      Attention: End of Life Option Act
      MS 5205

P. 0. Box 997377
Sacramento, CA 95899-7377
The forms can also be faxed to (916) 440-5209.

d) This disclosure to CDPH is permitted under state and federal privacy laws. However, the information must not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other legal proceedings in response to a subpoena.

H. Immunity from Liability

The Act contains several protections from civil or criminal liability or sanctions and penalties for physicians who choose to be involved with their patient and who comply with the provisions of the Act. A physician can be present at the time of drug ingestion or can assist the patient by preparing the drug and not be subject to liability or loss of license, or privileges.

REFERENCES: California Health & Safety Code, Division 1, Part 1.85 (443-443.22), Assembly Bill No. 15 amending the Health and Safety Code (effective 1/1/22).

APPROVAL SIGNATURES: See policy manager for electronic approval.

Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner

I,_____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

Initial One:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Sign: _____

Date: _____

Declaration of Witnesses

We declare that the person signing this request:

a. Is personally known to us or has provided proof of identity;

b. Voluntarily signed this request in our presence;

c. Is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

d. Is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

_____ _____

Witness 1 Signature *Date*

_____ _____

Witness 2 Signature *Date*

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

Interpreter

I, _____(insert name of interpreter), am fluent in English and _____ (insert target language).

On (insert date) at approximately (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to _____ (insert name of individual/patient) in _____ (insert target language).

Mr./Ms. _____ (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and _____(insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at _____ (insert city, county, and state) on this _____ (insert day of month) of _____ (insert month), _____ (insert year).

_____

Interpreter Signature

_____

Interpreter Printed Name

_____

Interpreter Address

End of Life Option Act
Attending Physician Checklist and Compliance Form

Patient Information

Patient's Name: _____
(last) *(first)* *(M.I.)*

Date of Birth: _____

Patient's Address: _____
(street)

_____
(city) *(zip code)*

Attending Physician Information

Physician's Name:_____
(last) *(first)* *(M.I.)*

Telephone Number: _____

Mailing Address: _____
(street)

_____
(city) *(zip code)*

Physician's License Number: _____

Consulting Physician Information

Physician's Name:_____
(last) *(first)* *(M.I.)*

Telephone Number: _____

Mailing Address: _____
(street)

_____
(city) *(zip code)*

Physician's License Number: _____

Eligibility Determination

1. Terminal Disease

_____

2. Check boxes for compliance. (Both the attending and consulting physicians must make these determinations.)

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that the patient is a resident of California.
- ☐ 3. Determination that the patient has the capacity to make medical decisions.1
- ☐ 4. Determination that patient is acting voluntarily.
- ☐ 5. Determination of capacity by mental health specialist, if necessary.
- ☐ 6. Determination that patient has made his/her decision after being fully informed of:
  - ☐ a. His or her medical diagnosis; and
  - ☐ b. His or her prognosis; and
  - ☐ c. The potential risks associated with ingesting the requested aid-in-dying drug;
  - ☐ d. The probable result of ingesting the aid-in-dying drug;
  - ☐ e. The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

Additional Compliance Requirements

- ☐ 1. Counseled patient about the importance of all of the following:
  - ☐ a. Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
  - ☐ b. Having another person present when he or she ingests the aid-in-dying drug;
  - ☐ c. Not ingesting the aid-in-dying drug in a public place;
  - ☐ d. Notifying the next of kin of his or her request for an aid-in-dying drug (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
  - ☐ e. Participating in a hospice program or palliative care program.
- ☐ 2. Informed patient of right to rescind request (1st time).
- ☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion.
- ☐ 5. First oral request for aid-in-dying (date): _____ Attending Physician (initials): _____
- ☐ 6. Second oral request for aid-in-dying (date): _____ Attending Physician (initials): _____
- ☐ 7. Written request for aid-in-dying (date): _____ Attending Physician (initials): _____
- ☐ 8. Offered patient right to rescind (2nd time).

Patient's Mental Status

Check one of the following (required):

- ☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist2 listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder.

Mental Health Specialist's Information, If Applicable:

_____
Name

_____
Title and License

_____
Mailing Address (street, city, zip code)

Medication Prescribed

Pharmacist Name: _____

- ☐ 1. Aid-in-dying medication prescribed:
  - ☐ a. Name: _____
  - ☐ b. Dosage: _____
- ☐ 2. Antiemetic medication prescribed:
  - ☐ a. Name: _____
  - ☐ b. Dosage: _____
- ☐ 3. Method prescription was delivered:
  - ☐ a. In person
  - ☐ b. By mail
  - ☐ c. Electronically
- ☐ 4. Date medication was prescribed: _____

Signature

_____ _____
Physician Signature Date

_____
Name (Please Print)

End of Life Option Act Consulting Physician Compliance Form

MARSHALL MEDICAL CENTER

Patient Information

Patient's Name: _____
(last) *(first)* *(M.I)*

Date of Birth: _____

Attending Physician Information

Physician's Name:_____
(last) *(first)* *(M.I)*

Telephone Number: _____

Consulting Physician's Report

1. Terminal Disease _____ Date of Examination(s) _____

2. Check boxes for compliance. (Both the attending and consulting physicians must make these determinations.)

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that the patient has the capacity to make medical decisions. [1]
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. Determination that patient has made his/her decision after being fully informed of:
  - ☐ a. His or her medical diagnosis; and
  - ☐ b. His or her prognosis; and
  - ☐ c. The potential risks associated with taking the drug to be prescribed; and
  - ☐ d. The potential result of taking the drug to be prescribed; and
  - ☐ e. The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

Patient's Mental Status

Check one of the following (required):

- ☐ I have determined that the individual has the capacity[1] to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist[2] listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder.

Mental Health Specialist's Information, If Applicable:

_____
Name

_____ _____
Telephone Number Date

Consultant's Information:

_____ _____
Telephone Number Date

_____
Name

_____ _____
Mailing Address Telephone Number

_____
City, State, Zip Code

1 “Capacity to make medical decisions” means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand the significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.

2 “Mental Health Specialist” means a psychiatrist or a licensed psychologist.

End of Life Option Act Attending Physician Follow-up Form

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____

Patient Name: _____

Attending Physician Name: _____

Cause of Death

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause, such as terminal sedation or ceasing to eat or drink?

☐ **Aid-in-dying drug (lethal dose)** — Please sign below and go to page 2.

Attending physician signature: _____

☐ **Underlying illness** — There is no need to complete the rest of the form. Please sign below.

Attending physician signature: _____

☐ **Other** — There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign.

Please Specify: _____

Attending physician signature: _____

Part A and Part B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

☐ The attending physician was present at the time of death.

The attending physician must complete this form in its entirety and sign Part A and Part B.

☐ The attending physician was not present at the time of death, but another licensed health care provider was present.

The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of this form.

☐ Neither the attending physician nor another licensed health care provider was present at the time of death.

Part A may be left blank. The attending physician must complete and sign Part B of this form.

Part A. To be completed and signed by the attending physician or another licensed health care provider present at death

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?
   ☐ Yes
   ☐ No

   If no: was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?
   ☐ Yes, another physician
   ☐ Yes, a trained health care provider/volunteer
   ☐ No
   ☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?
   ☐ Yes
   ☐ No

   If no: was another physician or licensed health care provider present at the patient's time of death?
   ☐ Yes, another physician or licensed health care provider
   ☐ No
   ☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying drug?
   (month/day/year) _____ ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
   (month/day/year) _____ ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?
   - ☐ Private home
   - ☐ Assisted-living residence
   - ☐ Nursing home
   - ☐ Acute care hospital in-patient
   - ☐ In-patient hospice resident
   - ☐ Other (specify) _____
   - ☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?
   Minutes _____ and/or _____ Hours ☐ Unknown

7. What was the time between lethal medication ingestion and death?
   Minutes _____ and/or _____ Hours ☐ Unknown

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?
   - ☐ Yes — vomiting, emesis
   - ☐ Yes — regained consciousness
   - ☐ No complications
   - ☐ Other — please describe: _____
   - ☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?
   - ☐ Yes — please describe: _____
   - ☐ No
   - ☐ Unknown

10 At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?
   - ☐ Yes
   - ☐ No, refused care
   - ☐ No, other (specify): _____

Signature

_____
Signature of attending physician present at time of death

_____
Name of licensed health care provider present at time of death if not attending physician

_____
Signature of licensed health care provider

Part B. To be completed and signed by the attending physician

1. On what date was the prescription written for the aid-in-dying drug? _____

2. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?
   ☐ Yes
   ☐ No, refused care
   ☐ No, other (specify) _____

3. What type of health care coverage did the patient have for their underlying illness? (Check all that apply)
   ☐ Medicare
   ☐ Medi-Cal
   ☐ Covered California
   ☐ V.A.
   ☐ Private insurance
   ☐ No insurance
   ☐ Had insurance, do not know type

4. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug. Please check "Yes," "No," or "Don't Know," depending on whether or not you believe that concern contributed to their request. *(Please check as many boxes as you think may apply.)*

   A concern about:

   a. His or her terminal condition representing a steady loss of autonomy
      ☐ Yes
      ☐ No
      ☐ Don't Know

   b. The decreasing ability to participate in activities that made life enjoyable
      ☐ Yes
      ☐ No
      ☐ Don't Know

   c. The loss of control of bodily functions
      ☐ Yes
      ☐ No
      ☐ Don't Know

   d. Persistent and uncontrollable pain and suffering
      ☐ Yes
      ☐ No
      ☐ Don't Know

   e. A loss of dignity
      ☐ Yes
      ☐ No
      ☐ Don't Know

   f. Other concerns (specify):
      _____
      _____
      _____

Signature

_____

Signature of attending physician