



## Patient Choice at End of Life — Physician Follow-up

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

Dear Physician:

The **Rule Governing Compliance with Patient Choice At End Of Life** requires physicians who write a prescription for a lethal dose of medication to complete this follow-up form within **10 calendar days** of a patient's death, if known to the physician, or **60 calendar days** from the writing of the prescription.

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

This form should be mailed to the address above. *All information is kept strictly confidential.* If you have any questions, call: 802-651-1862.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Prescribing Physician:** \_\_\_\_\_

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please mark the form indicating that.**

- 1. Patient Choice** (lethal medication)
- 2. Underlying illness**
- 3. Unknown**
- 4. Other** (please specify):

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**Prescribing Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_