VERMONT

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
280 State Drive Waterbury VT, 05671-8370

PLEASE PRINT

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

B	**REFERRING/PRESCRIBING PHYSICIAN INFORMATION**	
	NAME	TELEPHONE NUMBER (with area code)

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 (with area code)
	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.	
	X 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

02.15.2024