



COLORADO

Department of Public Health & Environment

Attending Physician Who Prescribes Medical Aid-in-Dying Medication Reporting Form

Mail completed form to:

Colorado Department of Public Health and Environment, Vital Statistics Program
4300 Cherry Creek Drive South, Denver, CO 80246-1530

(This form may be revised periodically. To assure that you are using the most current version, please refer to: <https://www.colorado.gov/cdphe>)

Please print:

A Patient Information			
Patient's Last Name	Patient's First Name	Middle Initial	Date of Birth
Medical Diagnosis			

B Attending Physician Information			
Physician's Last Name	Physician's First Name	Middle Initial	Telephone # ()
Mailing Address			
City, State and Zip Code			

C Actions Taken to Comply with the Law <i>(indicate compliance by checking the appropriate boxes.)</i>	
1. First Oral Request	
<input type="checkbox"/> The patient made an oral request for medical aid-in-dying medication.	Date
2. Second Oral Request (must be made 15 days or more after the first oral request)	
<input type="checkbox"/> The patient made a second oral request for medical aid-in-dying medication.	Date
3. Written Request	
<input type="checkbox"/> The patient made a written request for medical aid-in-dying medication	Date
<input type="checkbox"/> The written request complies with Sections 25-48-104 and 25-48-112, C.R.S. <i>(Please attach a copy of the written request.)</i>	
4. Physician Determinations	
Determined that the patient:	
<input type="checkbox"/> Is suffering with a terminal illness;*	
<input type="checkbox"/> Has a prognosis of six months less;**	
<input type="checkbox"/> Is mentally capable of making and communicating an informed decision <i>(If you obtained a written confirmation of mental capacity from a licensed mental health provider to assist you in making this determination, please attach a copy of the written confirmation.)</i> ;	
<input type="checkbox"/> Is voluntarily requesting medical aid-in-dying medication that has not been coerced or unduly influenced by others;	
<input type="checkbox"/> Is at least 18 years old and a Colorado state resident;***	
<input type="checkbox"/> Has been notified of the right to recind a request for aid-in-dying medication at any time and in any manner.	

(continue to page 2 on reverse side)

5. Consulting Physician Information			
<input type="checkbox"/> Referred the patient to a second physician for medical confirmation (Please attach a copy of the consulting physician's written confirmation of diagnosis, prognosis, and mental capacity determination.)			
Consulting Physician Last Name	First Name	Middle Initial	Telephone # ()
Mailing Address			
City, State and Zip Code			
D Medication Prescribed and Final Attestation			
1. Medical Aid-in-Dying Medication Prescribed			
Medication	Dose	Date	
2. Medical Aid-in-Dying Medication Dispensed			
<input type="checkbox"/> Dispensed medication directly to the patient.			Date
<input type="checkbox"/> Delivered a written prescription to a licensed pharmacist.			Date
<input type="checkbox"/> Notified pharmacist that the medication was prescribed for the purpose of medical aid in dying pursuant to statute.			Date
Pharmacy Name			Telephone # ()
City, State and Zip Code			
3. Final Attestation			
<input type="checkbox"/> To the best of my knowledge, all of the requirements of the Colorado End-of-Life Options Act have been met.			
Physician's Signature			Date

* Pursuant to Section 25-48-102(16), C.R.S., "Terminal illness" means an incurable and irreversible illness that will, within reasonable medical judgment, result in death.

** Pursuant to Section 25-48-102(12), C.R.S., "Prognosis of six months for less" means a prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.

*** Pursuant to Section 25-48-102(14), C.R.S., residency can only be documented with: 1) Possession of a Colorado driver's license or identification card; 2) a Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado; 3) evidence that the individual owns or leases property in Colorado; or 4) a Colorado income tax return for the most recent tax year. The prescribing physician is required to affirm Colorado residency.