COLORADO
Department of Public Health & Environment

Clear Form

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 *(indicate compliance by checking the appropriate boxes.)*

1. First Oral Request

☐ 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)

☐ The patient made a second oral request for medical aid-in-dying medication. — Date

3. Written Request

☐ The patient made a written request for medical aid-in-dying medication
☐ The written request complies with Sections 25-48-104 and 25-48-112, C.R.S. (*Please attach a copy of the written request.*) — Date

4. Physician Determinations

Determined that the patient:

☐ Is suffering with a terminal illness;*
☐ Has a prognosis of six months less;**
☐ Is mentally capable of making and communicating an informed decision *(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.)*;
☐ Is voluntarily requesting medical aid-in-dying medication that has not been coerced or unduly influenced by others;
☐ Is at least 18 years old and a Colorado state resident;***
☐ 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

☐ 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

☐ Dispensed medication directly to the patient. — Date

☐ Delivered a written prescription to a licensed pharmacist.
☐ 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

☐ 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.