New Jersey Department of Health

MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT
CONSULTING PHYSICIAN COMPLIANCE FORM

Filing Instructions:

1. This form must be completed by the Consulting Physician who determined that the person was a "qualified terminally ill patient" and met the other legal requirements for receiving medication under the Medical Aid in Dying Act (P.L.2019, c.59).
2. The Consulting Physician must deliver the completed form to the Attending Physician.
3. The Attending Physician must append this form to Attending Physician Compliance Form, which must be filed with the Office of the Chief State Medical Examiner no later than 30 days after the date of the qualified terminally ill patient's death.
4. Forms shall be filed with the New Jersey Office of the Chief State Medical Examiner at:
   PO Box 182
   Trenton, NJ 08625
   Or you may submit electronically via email at maid@doh.nj.gov

Date: _____
[Month/Day/Year]

PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

ATTENDING PHYSICIAN INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's Facility Name:			
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Physician's License Number:			

CONSULTING PHYSICIAN INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's Facility Name:			
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Physician's License Number:			

PATIENT ELIGIBILITY DETERMINATION BY CONSULTING PHYSICIAN

Terminal Illness, Disease, or Condition: _____

CHECK ALL THAT APPLY:

- ☐ Examined the patient and the patient's relevant medical records.
- ☐ Confirmed in writing the attending physician's diagnosis that the patient is terminally ill.
- ☐ Determined that the patient is terminally ill, is capable, has voluntarily made the request for medication, and has made an informed decision to request medication that, if prescribed, the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.).
- ☐ Informed the patient of the patient's medical diagnosis and prognosis.

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PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

Patient's Mental Status:

CHECK ONE:

☐ In my medical opinion, the patient requesting medication is capable.

☐ In my medical opinion, the patient may not be capable. I notified the attending physician in writing that I referred the patient to a mental health care professional. I subsequently referred the patient to a mental health care professional (listed below) who notified me and the attending physician in writing that that mental health care professional determined that the patient is capable.

MENTAL HEALTH PROFESSIONAL'S INFORMATION (IF REFERRAL IS APPLICABLE)			
Professional's Name:	*[Last Name, First Name, Middle Name]*	Professional's Telephone Number:	*[10-digit]*
Professional's Facility Name:			
Professional's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Professional's License Number:			

AUTHORIZATION

Signature: _____ Date: _____
[Month/Day/Year]