GOVERNMENT OF WESTERN AUSTRALIA

Department of **Health**

Voluntary assisted dying forms (examples)

Acknowledgement

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Contents

Voluntary Assisted Dying Board

First Request Form

Completed by the medical practitioner receiving a First Request for access to voluntary assisted dying.

The medical practitioner completes this form after the person has made a First Request for access to voluntary assisted dying. A medical practitioner must refuse a First Request if they are not eligible to act as a Coordinating Practitioner.

If the medical practitioner has a conscientious objection to voluntary assisted dying they must **immediately** inform the person that they are refusing the First Request.

In other cases, the medical practitioner must inform the person within **2 business days** after receiving the First Request.

In **all** cases the medical practitioner must:

1. complete this form; and
2. give a copy of it to the Voluntary Assisted Dying Board.

NB: on acceptance of a First Request the medical practitioner becomes the Coordinating Practitioner for the person.

A. Person/Patient information

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the person/patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields over the page.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Medical practitioner information

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Communication

Date of First Request (DD/MM/YYYY)

The First Request was made:

- ☐ In person
- ☐ Via audiovisual communication*
  - ☐ Confirm not practicable for First Request to be made in person
    *(*to be used **only** where it is not practicable for the First Request to be made in person)*
- ☐ During a medical consultation
- ☐ In a clear and unambiguous manner

Please indicate the method of communication the person used to make the First Request:

- ☐ Spoken language
- ☐ Sign language (AUSLAN)
- ☐ Augmentative and alternative communication
- ☐ Other effective non-spoken communication

Was the patient assisted by an interpreter when making the First Request?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

Note: *Interpreters must meet **all** of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

D. Details/outcome of First Request

I have decided to:

☐ Accept the First Request

☐ Refuse the First Request

If you are refusing the First Request, what is your reason?

☐ I conscientiously object to voluntary assisted dying

☐ I am unwilling to perform the duties of a Coordinating Practitioner

☐ I am unable to perform the duties of a Coordinating Practitioner (e.g. due to unavailability or other reason)

☐ I am ineligible to act as a Coordinating Practitioner
(Refer Appendix A for practitioner eligibility criteria)

*Within **2 business days** of the person making the First Request, you must inform the patient of your decision to accept or refuse the First Request (unless refusal is because of conscientious objection in which case the person must be informed **immediately**).*

Date person informed of outcome (DD/MM/YYYY) _____

*Within **2 business days** of the person making the request, you must give the information approved by the CEO (section 20(4)(b) of the Voluntary Assisted Dying Act 2019) (unless refusal is because of conscientious objection in which case the person must be given this information **immediately**).*

Date information referred to in section 20(4)(b) of the *Voluntary Assisted Dying Act 2019* was given to person (DD/MM/YYYY) _____

E. Signature of medical practitioner

Signature

Date (DD/MM/YYYY)

Print name

Within 2 business days of making the decision to accept or refuse the First Request you must:

1. **complete this form**
2. **give a copy to the Voluntary Assisted Dying Board**

You must record the following details in the patient's medical record:

- The First Request
- Your decision to accept or refuse the First Request
- If your decision is to refuse the First Request, the reason for the refusal
- Whether you have given the person the information referred to in section 20(4)(b) of the *Voluntary Assisted Dying Act 2019*.

Voluntary Assisted Dying Board

First Request Form

Completed by the medical practitioner receiving a First Request for access to voluntary assisted dying.

Appendix A: Practitioner eligibility criteria

There are eligibility requirements for a practitioner to act in the role of Coordinating Practitioner as per the *Voluntary Assisted Dying Act 2019* (the Act). These requirements are set out in section 17 of the Act (see extract below). The CEO requirements are outlined in Table 1.

Division 1 – Eligibility requirements for medical practitioners

17. Eligibility to act as coordinating practitioner or consulting practitioner

1. In this section –

   general registration means general registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   limited registration means limited registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   provisional registration means provisional registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   specialist registration means specialist registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession in a recognised specialty.

2. A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if –

   a. the medical practitioner –

      i. holds specialist registration, has practised the medical profession for at least 1 year as the holder of specialist registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

      ii. holds general registration, has practised the medical profession for at least 10 years as the holder of general registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

      iii. is an overseas-trained specialist who holds limited registration or provisional registration and meets the requirements approved by the CEO for the purposes of this subparagraph;

      and

   b. the medical practitioner is not a family member of the patient; and

   c. the medical practitioner does not know or believe that the practitioner –

      i. is a beneficiary under a will of the patient; or

      ii. may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Table 1

Section 17(2)(a)(i) COORDINATING or CONSULTING PRACTITIONER (specialist medical practitioner)	
1.1	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
1.2	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
1.3	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.
Section 17(2)(a)(ii) COORDINATING or CONSULTING PRACTITIONER (generalist medical practitioner)	
2.1	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
2.2	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
2.3	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.
Section 17(2)(a)(iii) COORDINATING or CONSULTING PRACTITIONER (overseas trained specialist medical practitioner)	
3.1	Medical practitioner must be permitted by their registration to work in a gazetted area of need OR as a sponsored provider within a health service in Western Australia.
3.2	Medical practitioner must have undergone formal assessment by the relevant Australian college.
3.3	Medical practitioner must have at least 5 years of experience as a specialist.
3.4	Medical practitioner must have had their specialist pathway and supervision program approved by the relevant Australian college and must have completed at least 12 months working in a supervised position within Western Australia.
3.5	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the 'Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
3.6	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
3.7	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.

Voluntary Assisted Dying Board

First Assessment Report Form

Completed by the Coordinating Practitioner.

This form is only to be completed:

i. for a patient who has made a valid First Request that has been accepted;

ii. by a Coordinating Practitioner who meets the eligibility criteria at section 17(2) of the *Voluntary Assisted Dying Act 2019* and who has successfully completed the approved training within the last 3 years;

iii. after the Coordinating Practitioner has completed the First Assessment of the patient.

The WA Voluntary Assisted Dying Guidelines should be used as a guide for completing the First Assessment.

As soon as practicable after completion of the First Assessment the Coordinating Practitioner must:

1. inform the patient of the outcome of the First Assessment; and
2. give a copy of this form to the patient.

Within **2 business days** after the completion of the First Assessment the Coordinating Practitioner must:

1. complete this form; and
2. give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields over the page.

Mailing Address (line 1)

Mailing Address (line 2)

Suburb

State Postcode

Telephone number

Email address

Gender ☐ Male ☐ Female ☐ Other (please specify)

Is the patient of Aboriginal and/or Torres Strait Islander origin?

☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander
☐ Yes, both Aboriginal and Torres Strait Islander

Was the patient born overseas? ☐ No ☐ Yes

If yes, in which country was the patient born?

Would the patient consider English as their first language? ☐ Yes ☐ No

If no, which language(s) would this be?

How well does the patient speak English?

☐ Very well
☐ Well
☐ Not well
☐ Not at all

What is the patient's ancestry (provide up to two ancestries only)?

☐ Australian ☐ Chinese
☐ English ☐ German
☐ Irish ☐ Indian
☐ Scottish ☐ Dutch
☐ Italian ☐ Filipino
☐ Other (ancestry 1; please specify)
☐ Other (ancestry 2; please specify)

Does the patient have a disability? ☐ No ☐ Yes

If yes, please specify

What is the patient's current relationship status?

- ☐ Divorced
- ☐ Married/De facto
- ☐ Never married
- ☐ Separated
- ☐ Widowed

Who does the patient usually live with?

- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with others

What is the highest level of education the patient has achieved?

- ☐ Primary school
- ☐ High school
- ☐ Year 12 graduation
- ☐ Trade certificate
- ☐ Advanced Diploma and Diploma
- ☐ Bachelor degree
- ☐ Postgraduate degree

The patient has indicated that their reason(s) for requesting voluntary assisted dying is (can select more than one option):

> ***NB:*** *the patient's reason for requesting voluntary assisted dying is not relevant to eligibility criteria and must not be taken into account by a Coordinating Practitioner when they assess a patient's eligibility for voluntary assisted dying.*

- ☐ Patient chose to not divulge reasons
- ☐ Losing autonomy, or concern about it
- ☐ Less able to engage in activities making life enjoyable, or concern about it
- ☐ Loss of dignity, or concern about it
- ☐ Losing control of bodily functions, or concern about it
- ☐ Burden on family, friends/caregivers, or concern about it
- ☐ Inadequate pain control, or concern about it
- ☐ Breathlessness, or concern about it
- ☐ Other (please specify)

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA registration number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing Address (line 1)

Mailing Address (line 2)

Suburb

State Postcode

Telephone number

Email address

☐ I, _____ , am eligible to act as a Coordinating Practitioner
Coordinating Practitioner Name
in accordance with section 17(2) of the *Voluntary Assisted Dying Act 2019*.

☐ I, _____ , have successfully completed the approved training
Coordinating Practitioner Name
in accordance with section 25 of the *Voluntary Assisted Dying Act 2019* within the last 3 years.

How long have you been providing care for this patient?

☐ No previous relationship

☐ Less than 12 months

☐ 12 months or more

C. Details of First Assessment – Eligibility criteria component

Date First Request made (DD/MM/YYYY)

In relation to the eligibility criteria, I have decided that the patient:

1. Has reached 18 years of age	☐ Yes ☐ No
2. Is an Australian citizen or permanent resident	☐ Yes ☐ No
3. At the time of making the First Request has been ordinarily resident in Western Australia for a period of at least 12 months	☐ Yes ☐ No
4. Has been diagnosed with at least 1 disease, illness or medical condition that: • Is advanced, progressive and will cause death • Will, on the balance of probabilities, cause death within a period of 6 months OR in the case of a neurodegenerative disease, illness or medical condition, within a period of 12 months • Is causing suffering to the patient that cannot be relieved in a manner that the patient considers tolerable	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
5. Has decision-making capacity in relation to voluntary assisted dying	☐ Yes ☐ No
6. Is acting voluntarily and without coercion	☐ Yes ☐ No
7. Has made a request for access to voluntary assisted dying that is enduring	☐ Yes ☐ No

Does the patient meet **all** of the eligibility criteria above? ☐ **Yes** ☐ **No**

Please provide details of patient diagnosis (disease, illness or medical condition):

Primary diagnosis

Secondary diagnosis(es)

Additional commentary

D: Referral for determination

I referred the patient to another registered health practitioner or person for determination.

- ☐ No (Go to Part E)
- ☐ Yes (please complete Appendix A for each referral made)

E: Palliative care and treatment options

Is the patient currently receiving palliative care?

- ☐ No
- ☐ Yes

If yes, from where are they receiving palliative care (see Appendix B for descriptions):

- ☐ General Practitioner
- ☐ Outpatient clinic
- ☐ Community or home-based palliative care
- ☐ Consultation in a facility
- ☐ Consultation in a hospital
- ☐ Specialist Palliative Care Unit

If no, have they received palliative care within the last 12 months?

- ☐ No
- ☐ Yes

What palliative care options are currently available to the patient, and what are the likely outcomes of these options?

What treatment options are currently available to the patient, and what are the likely outcomes of these options?

F. Communication during First Assessment

Was the patient assisted by an interpreter during the First Assessment?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below:

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

> ***Note:*** *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

G: Assessment outcome – Eligibility criteria component

Does the patient meet all of the eligibility criteria in Part C?

- ☐ No (The patient is **not** eligible for access to voluntary assisted dying. Go to Part I)
- ☐ Yes (Go to Part H)

H. Information to be provided if patient assessed as meeting eligibility criteria component

If the patient meets the eligibility criteria in Part C you must inform them about certain matters as detailed in section 27 of the *Voluntary Assisted Dying Act 2019* (refer to checklist in Appendix C).

☐ I am satisfied that the patient understands the information provided.

Did you engage an interpreter to communicate this information to the patient?

☐ No

☐ Yes

If yes, was the same interpreter used as during the First Assessment (details in Part F)?

☐ Yes

☐ No (please complete Appendix D)

I. Outcome of First Assessment

The Coordinating Practitioner must assess the patient as eligible for access to voluntary assisted dying if the Coordinating Practitioner is satisfied that:

1. The patient meets all of the eligibility criteria in Part C; and
2. The patient understands the information required to be provided under section 27(1).

If the Coordinating Practitioner is not satisfied as to any matter at (1) or (2) then the Coordinating Practitioner must assess the patient as ineligible for access to voluntary assisted dying.

I, _____ assess that the patient is:
Coordinating Practitioner Name

☐ Eligible for access to voluntary assisted dying

☐ Not eligible for access to voluntary assisted dying

Date of First Assessment completion (DD/MM/YYYY) _____

Date patient informed of First Assessment outcome (DD/MM/YYYY) _____

J. Signature of Coordinating Practitioner

Signature _____ Date (DD/MM/YYYY) _____

Print name _____

Within 2 business days after completing the First Assessment you must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

As soon as practicable after completing the First Assessment Report Form you must give a copy to the patient.

K. Information for patient on reviewable decisions

If the patient disagrees with a decision that the Coordinating Practitioner has made during the First Assessment they (or an eligible applicant as defined under section 83 of the *Voluntary Assisted Dying Act 2019*) can apply to the State Administrative Tribunal for review of **some** specific decisions. These include:

- whether or not they have been ordinarily resident in Western Australia for at least 12 months at time of the First Request; or
- whether or not they have decision-making capacity in relation to voluntary assisted dying; or
- whether or not they are acting voluntarily and without coercion.

For more information please visit the State Administrative Tribunal website https://sat.justice.wa.gov.au/ for details on the application process.

Voluntary Assisted Dying Board

First Assessment Report Form

Completed by the Coordinating Practitioner.

Appendix A: Referral for determination

Appendix A needs to be completed for **each** referral for determination that has been made. Additional copies of Appendix A can be made where more than one referral for determination has been made.

If the Coordinating Practitioner is unable to make the determination themselves, in accordance with section 26 (refer to the WA Voluntary Assisted Dying Guidelines for further information), the Coordinating Practitioner must refer the patient to a registered health practitioner or another person, as the case requires, who has the appropriate skills and training to make a determination in relation to the matter.

Where the Coordinating Practitioner has made a referral for determination, the Coordinating Practitioner may (but is not compelled to) adopt the determination of the practitioner or person to whom they have made the referral, in relation to the matter that was referred.

Copies of completed Appendix A(s), including any reports provided by the registered health practitioner or another person (as the case requires), must be given to the Voluntary Assisted Dying Board as part of the completed First Assessment Report Form.

Referral regarding patient's disease, illness or medical condition

I made a referral to a registered health practitioner with the appropriate skills and training in relation to whether the patient's disease, illness or medical condition meets the eligibility criteria:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient's disease, illness or medical condition meets the eligibility criteria according to section 16(1)(c)
- ☐ A determination that the patient's disease, illness or medical condition **does not** meet the eligibility criteria according to section 16(1)(c)
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the registered health
Coordinating Practitioner Name
practitioner to whom I have made a referral, that they are eligible to accept the referral for determination as detailed in section 26(5) of the *Voluntary Assisted Dying Act 2019*.

☐ I have attached copies of any reports given by a registered health practitioner regarding this referral for determination.

Referral regarding decision-making capacity in relation to voluntary assisted dying

I made a referral to a registered health practitioner with the appropriate skills and training in relation to whether the patient has decision-making capacity in relation to voluntary assisted dying:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient has decision-making capacity in relation to voluntary assisted dying
- ☐ A determination that the patient **does not** have decision-making capacity in relation to voluntary assisted dying
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the registered health
Coordinating Practitioner Name
practitioner to whom I have made a referral, that they are eligible to accept the referral for determination as detailed in section 26(5) of the *Voluntary Assisted Dying Act 2019*.

☐ I have attached copies of any reports given by a registered health practitioner regarding this referral for determination.

Referral regarding voluntariness and/or coercion

I made a referral to another person with appropriate skills and training in relation to whether the patient is acting voluntarily and without coercion:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient is acting voluntarily and without coercion
- ☐ A determination that the patient is **not** acting voluntarily and without coercion
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the person to whom
Coordinating Practitioner Name
I have made a referral, that they are eligible to accept the referral for determination as detailed in section 26(5) of the *Voluntary Assisted Dying Act 2019*.

☐ I have attached copies of any reports given by a person to whom I have made a referral regarding this referral for determination.

Voluntary Assisted Dying Board

First Assessment Report Form

Completed by the Coordinating Practitioner.

Appendix B: Guide to specialist palliative care services

Reference: https://ww2.health.wa.gov.au/Articles/F_I/Guide-to-specialist-palliative-care-services

Outpatient clinic

Providers include:

- Hollywood Private Hospital
- SJOG Hospital Subiaco
- SJOG Hospital Murdoch
- Fiona Stanley Hospital Palliative Care Consultancy Service
- WA Paediatric Palliative Care Service (WAPPCS)
- Rockingham General Hospital
- Royal Perth Hospital
- Sir Charles Gairdner Hospital
- SJOG Midland Public Private Hospital Palliative Care Service

Community or home-based palliative care

Providers include:

- WA Paediatric Palliative Care Service (WAPPCS)
- Silver Chain Hospice Care Service

Consultation in a facility

This service type covers:

- residential care
- disability service
- mental health service
- secondary hospital
- correctional facility

Providers include:

- Metropolitan Palliative Care Consultancy Service (MPaCCS)
- Silver Chain Hospice Care Service

Consultation in a hospital

Providers include:

- Bethesda Hospital
- Fiona Stanley Hospital
- Hollywood Private Hospital
- Joondalup Health Campus
- Metropolitan Palliative Care Consultancy Services
- Royal Perth Hospital
- Rockingham General Hospital
- Sir Charles Gairdner Hospital
- SJOG Hospital Murdoch
- SJOG Hospital Subiaco
- WA Paediatric Palliative Care Service (WAPPCS)
- SJOG Midland Public Private Hospital Palliative Care Service

Specialist Palliative Care Unit

Providers include:

- Bethesda Hospital Palliative Care Unit
- SJOG Murdoch Community Hospice
- Glengarry Hospital Palliative Care Unit
- Hollywood Private Hospital
- Kalamunda District Community Hospital Palliative Care Service
- Albany Community Hospice
- SJOG Bunbury Hospital Palliative Care Unit
- SJOG Geraldton Hospital Palliative Care Unit

Voluntary Assisted Dying Board

First Assessment Report Form

Completed by the Coordinating Practitioner.

Appendix C: Information to be provided to the patient if assessed as meeting eligibility criteria

The *Voluntary Assisted Dying Act 2019* requires certain information to be provided to a person if they are assessed as eligible by the Coordinating Practitioner.

The Coordinating Practitioner is also required to take all reasonable steps to explain additional aspects to the person and, if the person consents, another person that they nominate.

This checklist is provided as a tool to aid practitioners in meeting these requirements.

	Information to be provided by Coordinating Practitioner
☐	a. The person's diagnosis and prognosis
☐	b. The treatment options available to the person and the likely outcomes of that treatment
☐	c. The palliative care and treatment options available to the person and the likely outcomes of that care and treatment
☐	d. The potential risks of self-administering or being administered the voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the person's death
☐	e. The expected outcome of self-administering or being administered the substance referred to in paragraph (d) is death
☐	f. The method by which the substance referred to in paragraph (d) is likely to be self-administered or administered
☐	g. The request and assessment process, including the requirement for a Written Declaration signed in the presence of two (2) witnesses
☐	h. That if the person makes a self-administration decision, they must appoint a Contact Person
☐	i. That the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying
☐	j. That if the person is receiving ongoing health services from a medical practitioner other than the Coordinating Practitioner, the person is encouraged to inform the medical practitioner of their request for access to voluntary assisted dying
	Coordinating Practitioner to take all reasonable steps to fully explain to the person and, if they consent, another person they nominate:
☐	a. all relevant clinical guidelines
☐	b. a plan in respect of the administration of the voluntary assisted dying substance

Voluntary Assisted Dying Board

First Assessment Report Form

Completed by the Coordinating Practitioner.

Appendix D: Interpreter information

Appendix D only needs to be completed where:

- an interpreter was engaged to communicate the information under Part H of this form; and
- this interpreter was different to that used during the First Assessment (whose details are listed under Part F of this form).

Copies of completed Appendix D must be given to the Voluntary Assisted Dying Board as part of the completed First Assessment Report Form.

What type of interpreter service was required?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

> ***Note:*** *Interpreters must meet **all** of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has advised me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

Voluntary Assisted Dying Board

Consultation Referral Form

Completed by the medical practitioner receiving a Consultation Referral.

The medical practitioner completes this form after receiving a referral for a Consulting Assessment from the Coordinating Practitioner. A medical practitioner must refuse a Consultation Referral if they are not eligible to act as a Consulting Practitioner.

If a medical practitioner has a conscientious objection to voluntary assisted dying they must **immediately** inform the patient and Coordinating Practitioner that they refuse the Consultation Referral.

In other cases, the medical practitioner must inform the patient and Coordinating Practitioner within **2 business days** after receiving the referral.

In **all** cases the medical practitioner must:

1. complete this form; and
2. give a copy of it to the Voluntary Assisted Dying Board.

NB: on acceptance of a Consultation Referral the medical practitioner becomes the Consulting Practitioner for the patient, however cannot begin the Consulting Assessment until eligibility to act as a Consulting Practitioner has been confirmed (including successful completion of the approved training within the past 3 years).

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields over the page.

Mailing Address (line 1)

Mailing Address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Medical practitioner information

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Details of Consultation Referral

Date referral made (DD/MM/YYYY)

Date referral received (DD/MM/YYYY)

D. Outcome of Consultation Referral

I have decided to:

- ☐ Accept the Consultation Referral
- ☐ Refuse the Consultation Referral

If you are refusing the Consultation Referral, what is your reason?

- ☐ I conscientiously object to voluntary assisted dying
- ☐ I am unwilling to perform the duties of a Consulting Practitioner
- ☐ I am unable to perform the duties of a Consulting Practitioner (e.g. due to unavailability or other reason)
- ☐ I am ineligible to act as a Consulting Practitioner
  (Refer Appendix A for practitioner eligibility criteria)

*Within **2 business days** after receiving the referral, you must inform the patient and the Coordinating Practitioner of your decision to accept or refuse the Consultation Referral (unless refusal is because of conscientious objection in which case you must inform the patient and the Coordinating Practitioner **immediately** after receiving the referral).*

Date patient informed of outcome (DD/MM/YYYY)

Date Coordinating Practitioner informed of outcome (DD/MM/YYYY)

E. Signature of medical practitioner

Signature

Date (DD/MM/YYYY)

Print name

Within 2 business days of making the decision to accept or refuse the referral for a Consulting Assessment you must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The referral
- Your decision to accept or refuse the Consultation Referral
- If your decision is to refuse the referral, the reason for the refusal.

Voluntary Assisted Dying Board

Consultation Referral Form

Completed by the medical practitioner receiving a Consultation Referral.

Appendix A: Practitioner eligibility criteria

There are eligibility requirements for a practitioner to act in the role of Consulting Practitioner as per the *Voluntary Assisted Dying Act 2019* (the Act). These requirements are set out in section 17 of the Act (see extract below). The CEO requirements are outlined in Table 1.

Division 1 – Eligibility requirements for medical practitioners

17. Eligibility to act as coordinating practitioner or consulting practitioner

1. In this section –

   general registration means general registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   limited registration means limited registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   provisional registration means provisional registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession;

   specialist registration means specialist registration under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession in a recognised specialty.

2. A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if –

   a. the medical practitioner –

      i. holds specialist registration, has practised the medical profession for at least 1 year as the holder of specialist registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

      ii. holds general registration, has practised the medical profession for at least 10 years as the holder of general registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

      iii. is an overseas-trained specialist who holds limited registration or provisional registration and meets the requirements approved by the CEO for the purposes of this subparagraph;

      and

   b. the medical practitioner is not a family member of the patient; and

   c. the medical practitioner does not know or believe that the practitioner –

      i. is a beneficiary under a will of the patient; or

      ii. may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Table 1

Section 17(2)(a)(i) COORDINATING or CONSULTING PRACTITIONER (specialist medical practitioner)	
1.1	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
1.2	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
1.3	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.
Section 17(2)(a)(ii) COORDINATING or CONSULTING PRACTITIONER (generalist medical practitioner)	
2.1	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
2.2	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
2.3	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.
Section 17(2)(a)(iii) COORDINATING or CONSULTING PRACTITIONER (overseas trained specialist medical practitioner)	
3.1	Medical practitioner must be permitted by their registration to work in a gazetted area of need OR as a sponsored provider within a health service in Western Australia.
3.2	Medical practitioner must have undergone formal assessment by the relevant Australian college.
3.3	Medical practitioner must have at least 5 years of experience as a specialist.
3.4	Medical practitioner must have had their specialist pathway and supervision program approved by the relevant Australian college and must have completed at least 12 months working in a supervised position within Western Australia.
3.5	Medical practitioner must have clinically practised twice the minimum hours per registration period described in the 'Recency of Practice Registration Standard published by the Medical Board of Australia and this clinical practice must include patient assessment and clinical decision making.
3.6	Medical practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for roles under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
3.7	The CEO must be satisfied as to the suitability of the medical practitioner for roles under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the medical practitioner.

Voluntary Assisted Dying Board

Consulting Assessment Report Form

Completed by the Consulting Practitioner.

This form is only to be completed by a Consulting Practitioner who meets the eligibility criteria at section 17(2) and who has successfully completed the approved training within the last 3 years.

The Consulting Practitioner must assess and form their own opinions of the patient's eligibility for access to voluntary assisted dying, independently of the Coordinating Practitioner.

The Consulting Practitioner is to complete this form after completing the Consulting Assessment of the patient.

The WA Voluntary Assisted Dying Guidelines should be used as a guide for completing the Consulting Assessment.

As soon as practicable after completion of the Consulting Assessment the Consulting Practitioner must:

1. inform the patient and Coordinating Practitioner of the outcome of the Consulting Assessment; and
2. provide a copy of this form to the patient and Coordinating Practitioner.

Within **2 business days** after the completion of the Consulting Assessment the Consulting Practitioner must:

1. complete this form; and
2. give a copy of the completed form to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields over the page.

Mailing Address (line 1)

Mailing Address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Consulting Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

☐ I, _____ , am eligible to act as a Consulting Practitioner for
Consulting Practitioner Name
this patient in accordance with section 17(2) the *Voluntary Assisted Dying Act 2019*.

☐ I, _____ , have successfully completed the approved training
Consulting Practitioner Name
in accordance with section 36 of the *Voluntary Assisted Dying Act 2019* within the last 3 years.

C. Details of Consulting Assessment

Date First Request made (DD/MM/YYYY)

Date referral for Consulting Assessment made (DD/MM/YYYY)

Date referral for Consulting Assessment received (DD/MM/YYYY)

In relation to the eligibility criteria, I have decided that the patient:

1. Has reached 18 years of age	☐ Yes ☐ No
2. Is an Australian citizen or permanent resident	☐ Yes ☐ No
3. At the time of making the First Request has been ordinarily resident in Western Australia for a period of at least 12 months	☐ Yes ☐ No
4. Has been diagnosed with at least one (1) disease, illness or medical condition that: • Is advanced, progressive and will cause death • Will, on the balance of probabilities, cause death within a period of six (6) months OR in the case of a neurodegenerative disease, illness or medical condition, within a period of 12 months • Is causing suffering to the patient that cannot be relieved in a manner that the patient considers tolerable	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
5. Has decision-making capacity in relation to voluntary assisted dying	☐ Yes ☐ No
6. Is acting voluntarily and without coercion	☐ Yes ☐ No
7. Has made a request for access to voluntary assisted dying that is enduring	☐ Yes ☐ No

Does the patient meet **all** of the eligibility criteria above? ☐ **Yes** ☐ **No**

Please provide details of patient diagnosis (disease, illness or medical condition):

Primary diagnosis

Secondary diagnosis(es)

Additional commentary

D. Referral for determination

I referred the patient to another registered health practitioner or person for determination:

- ☐ No (Go to Part E)
- ☐ Yes (please complete Appendix A for each referral made)

E. Palliative care and treatment options

What palliative care options are currently available to the patient, and what are the likely outcomes of these options?

What treatment options are currently available to the patient, and what are the likely outcomes of these options?

F. Communication during Consulting Assessment

Was the patient assisted by an interpreter during the Consulting Assessment?

☐ No

☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE):

What type of interpreter service was required for the patient?

☐ Spoken language other than English

☐ Non-spoken communication (e.g. AUSLAN)

Note: *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has advised me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

G. Outcome of Consulting Assessment – Eligibility criteria component

Does the patient meet all of the eligibility criteria in Part C?

☐ No (The patient is **not** eligible for access to voluntary assisted dying. Go to Part I)

☐ Yes (Go to Part H)

H. Information to be provided if patient assessed as meeting eligibility criteria component

If the patient meets the eligibility criteria in Part C you must inform them about certain matters as in section 27 of the *Voluntary Assisted Dying Act 2019* (refer to checklist in Appendix B).

☐ I am satisfied that the patient understands the information provided.

Did you engage an interpreter to communicate this information to the patient?

☐ No

☐ Yes

If yes, was the same interpreter used as during the Consulting Assessment (whose details appear at Part F)?

☐ Yes

☐ No (please complete Appendix C)

I. Outcome of Consulting Assessment

The Consulting Practitioner must assess the patient as eligible for access to voluntary assisted dying if the Consulting Practitioner is satisfied that:

1. The patient meets all of the eligibility criteria in Part C; and
2. The patient understands the information required to be provided under section 27(1).

If the Consulting Practitioner is not satisfied as to any matter at (1) or (2) then the Consulting Practitioner must assess the patient as ineligible for access to voluntary assisted dying.

I assess that the patient is: ☐ Eligible for access to voluntary assisted dying

☐ Not eligible for access to voluntary assisted dying

Date of Consulting Assessment completion (DD/MM/YYYY) _____

Date patient informed of Consulting Assessment outcome (DD/MM/YYYY) _____

Date Coordinating Practitioner informed of Consulting Assessment outcome (DD/MM/YYYY) _____

J. Signature of Consulting Practitioner

Signature _____ Date (DD/MM/YYYY) _____

Print name _____

Within 2 business days of completing the Consulting Assessment, you must:

1. **complete this form; and**
2. **give a copy of it to the Voluntary Assisted Dying Board.**

As soon as practicable after completing the Consulting Assessment Report Form you must give a copy:

1. **to the patient; and**
2. **to the Coordinating Practitioner.**

K. Information for patient on reviewable decisions

If the patient disagrees with a decision that the Consulting Practitioner has made during the Consulting Assessment they (or an eligible applicant as defined under section 83 of the *Voluntary Assisted Dying Act 2019*) can apply to the State Administrative Tribunal for review of **some** specific decisions. These include:

- whether or not they have been ordinarily resident in Western Australia for at least 12 months at time of the First Request; or
- whether or not they have decision-making capacity in relation to voluntary assisted dying; or
- whether or not they are acting voluntarily and without coercion.

For more information please visit the State Administrative Tribunal website https://sat.justice.wa.gov.au/ for details on the application process.

Voluntary Assisted Dying Board

Consulting Assessment Report Form

Completed by the Consulting Practitioner.

Appendix A: Referral for determination

Appendix A needs to be completed for **each** referral for determination that has been made. Additional copies of Appendix A can be made where more than one referral for determination has been made.

If the Consulting Practitioner is unable to make the determination themselves, in accordance with section 37 (refer to the WA Voluntary Assisted Dying Guidelines for further information), the Consulting Practitioner must refer the patient to a registered health practitioner or another person, as the case requires, who has the appropriate skills and training to make a determination in relation to the matter.

Where the Consulting Practitioner has made a referral for determination, the Consulting Practitioner may (but is not compelled to) adopt the determination of the practitioner or person to whom they have made the referral, in relation to the matter that was referred.

Copies of completed Appendix A(s), including any reports provided by the registered health practitioner or another person (as the case requires), must be given to the Voluntary Assisted Dying Board as part of the completed Consulting Assessment Report Form.

Referral regarding patient's disease, illness or medical condition

I made a referral to a registered health practitioner with the appropriate skills and training in relation to whether the patient's disease, illness or medical condition meets the eligibility criteria:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient's disease, illness or medical condition meets the eligibility criteria according to section 16(1)(c)
- ☐ A determination that the patient's disease, illness or medical condition **does not** meet the eligibility criteria according to section 16(1)(c)
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the registered health
Consulting Practitioner Name
practitioner to whom I have made a referral, that they are eligible to accept the referral for determination as detailed in section 37(5) of the *Voluntary Assisted Dying Act 2019*.

☐ I have attached copies of any reports given by a registered health practitioner regarding this referral for determination.

Referral regarding decision-making capacity in relation to voluntary assisted dying

I made a referral to a registered health practitioner with the appropriate skills and training in relation to whether the patient has decision-making capacity in relation to voluntary assisted dying:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient has decision-making capacity in relation to voluntary assisted dying
- ☐ A determination that the patient **does not** have decision-making capacity in relation to voluntary assisted dying
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the registered health
Consulting Practitioner Name
practitioner to whom I have made a referral, that they are eligible to accept the referral for determination as detailed in section 37(5) of the *Voluntary Assisted Dying Act 2019*.

☐ I have attached copies of any reports given by a registered health practitioner regarding this referral for determination.

Referral regarding voluntariness and/or coercion

I made a referral to another person with appropriate skills and training in relation to whether the patient is acting voluntarily and without coercion:

- ☐ No
- ☐ Yes

If yes, the outcome of this referral was:

- ☐ A determination that the patient is acting voluntarily and without coercion
- ☐ A determination that the patient is **not** acting voluntarily and without coercion
- ☐ A determination was not able to be made

☐ I, _____ , have been advised by the person to whom I have
Consulting Practitioner Name
made a referral, that they are eligible to accept the referral for determination as detailed in section 37(5) of the *Voluntary Assisted Dying Act 2019.*

☐ I have attached copies of any reports given by a person to whom I have made a referral regarding this referral for determination.

Voluntary Assisted Dying Board

Consulting Assessment Report Form

Completed by the Consulting Practitioner.

Appendix B: Information to be provided to the patient if assessed as meeting eligibility criteria

The *Voluntary Assisted Dying Act 2019* requires certain information to be provided to a patient if they are assessed as eligible by the Consulting Practitioner.

This checklist is provided as a tool to aid practitioners in meeting these requirements.

Information to be provided by Consulting Practitioner	
☐	a. The person's diagnosis and prognosis
☐	b. The treatment options available to the person and the likely outcomes of that treatment
☐	c. The palliative care and treatment options available to the person and the likely outcomes of that care and treatment
☐	d. The potential risks of self-administering or being administered the voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the person's death
☐	e. The expected outcome of self-administering or being administered the substance referred to in paragraph (d) is death
☐	f. The method by which the substance referred to in paragraph (d) is likely to be self-administered or administered
☐	g. The request and assessment process, including the requirement for a Written Declaration signed in the presence of two (2) witnesses
☐	h. That if the person makes a self-administration decision, they must appoint a Contact Person
☐	i. That the person may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying
☐	j. That if the person is receiving ongoing health services from a medical practitioner other than the Coordinating Practitioner, the person is encouraged to inform the medical practitioner of their request for access to voluntary assisted dying

Voluntary Assisted Dying Board

Consulting Assessment Report Form

Completed by the Consulting Practitioner.

Appendix C: Interpreter information

Appendix C needs to be completed where:

- an interpreter was engaged to communicate the information under Part H of this form; and
- this interpreter was different to that used during the Consulting Assessment (whose details are listed at Part F of this form).

Copies of completed Appendix C must be given to the Voluntary Assisted Dying Board with the completed Consultation Assessment Report Form.

What type of interpreter service was required?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

> ***Note:*** *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

Voluntary Assisted Dying Board

Written Declaration

Completed by the patient, 2 eligible witnesses and, if relevant, an interpreter.

This Written Declaration may be completed by the patient after they have been assessed as eligible for access to voluntary assisted dying by both the Coordinating Practitioner and the Consulting Practitioner.

The patient (or another person on the patient's behalf) must sign this Written Declaration in the presence of two eligible witnesses (refer to part D to see if you are an eligible witness). Part D must be completed by the first witness. Part E must be completed by the second witness.

If the patient gives their Coordinating Practitioner a Written Declaration, within **2 business days** of receiving it the Coordinating Practitioner must give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is your mailing address different to your home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing Address (line 1)

Mailing Address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is the Coordinating Practitioner's mailing address different to their work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Patient Declaration

☐ I, _____ , declare that I make this request for access to
Patient Name
voluntary assisted dying voluntarily and without coercion and I understand its nature and effect.

Signature of patient Date (DD/MM/YYYY)

(in the presence of two eligible witnesses)

If the patient is unable to sign the Declaration, the section below applies

Another person can sign this Declaration on the patient's behalf, in the presence of the patient and the two eligible witnesses, if:

- the patient is unable to sign this Declaration themselves; and
- the patient has expressly directed the person to sign the Declaration; and
- the person is not either of the witnesses to this Declaration or the Coordinating or Consulting Practitioner for the patient; and
- the person has reached 18 years of age.

Name of person (print name) _____

Signature of person _____ Date (DD/MM/YYYY) _____

(in the presence of the patient and two eligible witnesses)

D. Certification of witnesses to signing of Written Declaration

A person is an "**ineligible** witness" if they:

- are under 18 years of age;
- know or believe that they are a beneficiary under a will of the patient;
- know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are a family member of the patient; and
- are the Coordinating or Consulting Practitioner for the patient.

First witness

☐ I, _____ (Witness Name), am not knowingly an ineligible witness and certify that in my presence, and in the presence of the second witness, _____ (Patient Name) appeared to freely and voluntarily sign this Declaration.

OR if patient directs another person to sign on their behalf:

☐ I, _____ (Witness Name), am not knowingly an ineligible witness and certify that in my presence, _____ (Patient Name) appeared to freely and voluntarily direct _____ (Other Person Name) to sign this Declaration and _____ (Other Person Name) signed this Declaration in the presence of _____ (Patient Name), myself and the second witness.

Signature of first witness _____ Date (DD/MM/YYYY) _____

E. Second witness

☐ I, _____ (Witness Name), am not knowingly an ineligible witness and certify that in my presence, and in the presence of the first witness, _____ (Patient Name) appeared to freely and voluntarily sign this Declaration.

OR if patient directs another person to sign on their behalf:

☐ I, _____ (Witness Name), am not knowingly an ineligible witness and certify that in my presence, _____ (Patient Name) appeared to freely and voluntarily direct

_____ (Other Person Name) to sign this Declaration and

_____ (Other Person Name) signed this Declaration in the presence of

_____ (Patient Name), myself and the first witness.

Signature of second witness _____ Date (DD/MM/YYYY) _____

F. Communication

Did you make the Written Declaration with the assistance of an interpreter?

☐ No
☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required?

☐ Spoken language other than English
☐ Non-spoken communication (e.g. AUSLAN)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address

Accreditation details (Practitioner Number)

☐ I, _____ , certify that I have provided a true and correct translation of
Interpreter Name

the material translated to assist _____ to make this Declaration.
Patient Name

***Note:** You must meet **all** of the criteria below to be an interpreter for this patient under the Act.*

☐ I, _____ , certify that I:
Interpreter Name

- am accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- am **not** a family member of the patient;
- do **not** know or believe that I am a beneficiary under a will of the patient;
- do **not** know or believe that I may otherwise benefit financially or in any other material way from the death of the patient;
- am **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- am **not** directly involved in providing health services or professional care services to the patient.

Signature of interpreter

Date (DD/MM/YYYY)

For stamp

Next steps

Please give this Written Declaration to the Coordinating Practitioner.

Coordinating Practitioner next steps

The Coordinating Practitioner must record the following details in the patient's medical record:

- The date when the Written Declaration was made
- The date when the Written Declaration was received by the Coordinating Practitioner

Within **2 business days** after receiving this Written Declaration the Coordinating Practitioner must give a copy to the Voluntary Assisted Dying Board.

Voluntary Assisted Dying Board

Final Request Form

Completed by the Coordinating Practitioner.

This form is only to be completed:

a. after the patient has made a Written Declaration requesting access to voluntary assisted dying;
b. by the eligible Coordinating Practitioner who has successfully completed the approved training within the last 3 years;
c. after the patient has made a Final Request for access to voluntary assisted dying.

Within **2 business days** after receiving a Final Request the Coordinating Practitioner must:

1. complete this form; and
2. give a copy of it to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Communication

The Final Request was made:

- ☐ In person
- ☐ Via audiovisual communication*
  - ☐ Confirm not practicable for Final Request to be made in person
    *(*to be used **only** where it is not practicable for the Final Request to be made in person)*
- ☐ In a clear and unambiguous manner

Please indicate the method of communication the patient used to make the Final Request:

- ☐ Spoken language
- ☐ Sign language (AUSLAN)
- ☐ Augmentative and alternative communication
- ☐ Other effective non-spoken communication

Was the patient assisted by an interpreter when making the Final Request?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

> ***Note:*** *Interpreters must meet **all** of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Telephone number

Email address

Accreditation details (Practitioner Number)

D. Details of Final Request

Date First Request made (DD/MM/YYYY)

Date Final Request made (DD/MM/YYYY)

"Designated period" means the period of 9 days beginning on the day on which the patient made the First Request. The Final Request cannot be made before the end of the designated period, except as follows.

The Final Request can be made before the end of the designated period (but no sooner than the day after the Consulting Assessment in which the patient was assessed as eligible for access to voluntary assisted dying) if in your opinion the patient is likely to die or lose decision-making capacity in relation to voluntary assisted dying before the end of the designated period and this opinion is consistent with that of the Consulting Practitioner.

If the Final Request was made before the end of the designated period, what was the reason?

- ☐ in my opinion, the patient is likely to die before the end of the designated period; or
- ☐ in my opinion, the patient is likely to lose decision-making capacity in relation to voluntary assisted dying before the end of the designated period.

I have conferred with the Consulting Practitioner in relation to the above reason(s), and:

- ☐ my opinion **IS** consistent with that of the Consulting Practitioner
- ☐ my opinion **IS NOT** consistent with that of the Consulting Practitioner. If this is the case, **the Final Request cannot be made until the end of the designated period**.

E. Signature of Coordinating Practitioner

Signature | Date (DD/MM/YYYY)

Print name

Within 2 business days of receiving a Final Request you must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The date when the Final Request was made.
- If the Final Request was made before the end of the designated period, the reason for it being made before the end of that period.

Voluntary Assisted Dying Board

Final Review Form

Completed by the Coordinating Practitioner.

This form is only to be completed by the eligible Coordinating Practitioner who has successfully completed the approved training within the last 3 years.

Once the Coordinating Practitioner has received a Final Request to access voluntary assisted dying from the patient, the Coordinating Practitioner must conduct a Final Review.

The Coordinating Practitioner must complete this form after they have conducted the Final Review.

Within **2 business days** after completing the Final Review Form the Coordinating Practitioner must give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State | Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

C. Communication

Was the patient assisted by an interpreter?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

> ***Note:*** *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

D. Details of Final Review

I, _____ ,
Coordinating Practitioner Name

☐ have reviewed, in respect of _____ :
Patient Name

- ☐ the First Assessment Report Form,
- ☐ all Consulting Assessment Report Forms, and
- ☐ the Written Declaration;

☐ in conducting this Final Review, have had regard to any decision made by the State Administrative Tribunal in respect of a decision made in the voluntary assisted dying request and assessment process;

☐ certify that the voluntary assisted dying request and assessment process for _____ has been completed in accordance with the *Voluntary Assisted Dying Act 2019**;
Patient Name

☐ certify that I am satisfied that _____ has decision-making capacity in relation to voluntary assisted dying;
Patient Name

☐ certify that I am satisfied that in requesting access to voluntary assisted dying, _____ is acting voluntarily and without coercion;
Patient Name

☐ certify that I am satisfied that _____ 's request to access voluntary assisted dying is enduring.
Patient Name

If you cannot certify any of the above matters, the request for access to voluntary assisted dying cannot proceed.

*The validity of the request and assessment process is not affected by any minor or technical error in this form or the forms reviewed as part of this Final Review. Please see the WA Voluntary Assisted Dying Guidelines for guidance on what might be considered a 'minor or technical error'.

E. Signature of Coordinating Practitioner

Signature _____ Date (DD/MM/YYYY) _____

Print name _____

Within 2 business days of completing the Final Review Form you must give a copy to the Voluntary Assisted Dying Board.

Voluntary Assisted Dying Board

Administration Decision and Prescription Form

Completed by the Coordinating Practitioner.

This form is only to be completed by the Coordinating Practitioner who meets the eligibility criteria at section 17(2) and who has successfully completed the approved training within the last 3 years.

The Coordinating Practitioner is to complete this form after prescribing a voluntary assisted dying substance for a patient.

Within **2 business days** of prescribing a voluntary assisted dying substance for the patient the Coordinating Practitioner must:

1. complete this form;
2. give a copy of the form to the Voluntary Assisted Dying Board; and
3. if the patient has made a self-administration decision, give a copy of the patient's Contact Person Appointment Form to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Coordinating Practitioner information

Unique supplier ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Communication

The administration decision was made:

- ☐ In person
- ☐ Via audiovisual communication*
  - ☐ Confirm not practicable for administration decision to be made in person
    *(*to be used **only** where it is not practicable for the administration decision to be made in person)*
- ☐ In a clear and unambiguous manner

Please indicate the method of communication the person used to make the administration decision:

- ☐ Spoken language
- ☐ Sign language (AUSLAN)
- ☐ Augmentative and alternative communication
- ☐ Other effective non-spoken communication

Was the patient assisted by an interpreter when making the administration decision?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

***Note:** Interpreters must meet **all** of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Telephone number

Email address

Accreditation details (Practitioner Number)

D. Administration decision

The patient has made a:

☐ Self-administration decision

☐ Practitioner administration decision

I have advised the patient that self-administration is inappropriate having regard to (select all that are applicable):

☐ the ability of the patient to self-administer the substance

☐ the patient's concerns about self-administering the substance

☐ the method for administering the substance that is suitable for the patient.

Date administration decision was made (DD/MM/YYYY)

E. Prescription related actions

Self-administration decision

☐ I have informed the patient, in writing, of the information required by section 69(2) of the *Voluntary Assisted Dying Act 2019* prior to prescribing the voluntary assisted dying substance.

☐ The patient has provided me with a copy of the Contact Person Appointment Form.

Or

Practitioner administration decision

☐ I have informed the patient, in writing, of the information required by section 69(3) of the *Voluntary Assisted Dying Act 2019* prior to prescribing the voluntary assisted dying substance.

Date prescription for voluntary assisted dying substance issued (DD/MM/YYYY)

- ☐ The substance/s for Protocol 1 were prescribed
- ☐ The substance/s for Protocol 2 were prescribed
- ☐ The substance/s for Protocol 3 were prescribed
- ☐ The substance/s for Protocol 4 were prescribed
- ☐ The substance/s for Protocol 5 were prescribed
- ☐ The substance/s for Protocol 5a were prescribed
- ☐ The substance/s for Protocol 5b were prescribed
- ☐ The substance/s for Protocol 5c were prescribed

F. Signature of Coordinating Practitioner

Signature

Date (DD/MM/YYYY)

Print name

Within 2 business days of prescribing a voluntary assisted dying substance for the patient you must:

1. **complete this form;**
2. **give a copy to the Voluntary Assisted Dying Board; and**
3. **if the patient has made a self-administration decision, give a copy of the patient's Contact Person Appointment Form to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The administration decision.

Voluntary Assisted Dying Board

Contact Person Appointment Form

Completed by the patient and appointed Contact Person.

This form (except for Part E) is to be completed by the patient who has made a self-administration decision in relation to voluntary assisted dying. If the patient is unable to complete the form they may direct another person to complete it on their behalf.

The patient must appoint a Contact Person, with that person's consent to their appointment indicated by their signature at Part E of this form.

The Contact Person must be 18 years or older to act as the Contact Person. The Contact Person may be the Coordinating Practitioner, the Consulting Practitioner, a registered health practitioner or another person.

The Contact Person will be sent detailed information about their obligations as Contact Person by the Voluntary Assisted Dying Board.

The patient or Contact Person must give the form to the Coordinating Practitioner.

If the Coordinating Practitioner is given a Contact Person Appointment Form, they must give a copy to the Voluntary Assisted Dying Board within **2 business days** after receiving it.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is your mailing address different to your home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is the Coordinating Practitioner's mailing address different to their work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Contact Person information

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the Contact Person's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

D. Communication

Did you make the appointment of the Contact Person with the assistance of an interpreter?

☐ No

☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required?

☐ Spoken language other than English

☐ Non-spoken communication (e.g. AUSLAN)

Note: *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

E. Statement of Contact Person

☐ I, _____ consent to my appointment as Contact Person for
Contact Person Name

_____ .
Patient Name

☐ I understand the requirements of my role under the *Voluntary Assisted Dying Act 2019*, including:

- the requirements under section 105 to give the prescribed substance, or any unused or remaining prescribed substance, to an Authorised Disposer, and that penalties apply for non-compliance with these requirements; and
- the requirements under section 67(2) to inform the patient's Coordinating Practitioner if the patient dies, whether as a result of self-administering the prescribed substance or from some other cause.

☐ I consent

OR

☐ I do not consent

- to the Voluntary Assisted Dying Board contacting me to advise that the prescribed voluntary assisted dying substance for the patient has been supplied to a person other than me.

Signature _____ Date (DD/MM/YYYY) _____

F. Consent statement and signature of patient

I, _____ have appointed _____
Patient Name Contact Person Name

as my Contact Person.

I, _____
Patient Name

☐ consent

OR

☐ do not consent

- to the Voluntary Assisted Dying Board informing _____ that the prescribed voluntary assisted dying substance has been supplied for me.
Contact Person Name

Signature of patient _____ Date (DD/MM/YYYY) _____

If the patient is unable to sign, the section below applies

Another person can complete this form on the patient's behalf if:

- the patient is unable to complete this form themselves; and
- the patient has directed the person to complete this form; and
- the person has reached 18 years of age; and
- the person signs the form in the presence of the patient.

Name of person (print name) _____

Signature of person _____ Date (DD/MM/YYYY) _____

(in the presence of the patient)

Next steps

This form must be given to the Coordinating Practitioner by the patient or the Contact Person.

Coordinating Practitioner next steps

Within **2 business days** after receiving this Contact Person Appointment Form the Coordinating Practitioner must give a copy to the Voluntary Assisted Dying Board.

Voluntary Assisted Dying Board

Authorised Supply Form

Completed by the Authorised Supplier.

This form is only to be completed by an Authorised Supplier, as defined in sections 79(1) and 79(2) of the *Voluntary Assisted Dying Act 2019*.

This form is to be completed **immediately** after supplying the voluntary assisted dying substance.

Within **2 business days** after supplying the prescribed substance the Authorised Supplier must give a copy of it to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Authorised Supplier information

Unique supplier ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Details of Authorised Supply

☐ The prescribed substance/s for Protocol 1 were supplied

☐ The prescribed substance/s for Protocol 2 were supplied

☐ The prescribed substance/s for Protocol 3 were supplied

☐ The prescribed substance/s for Protocol 4 were supplied

☐ The prescribed substance/s for Protocol 5 were supplied

☐ The prescribed substance/s for Protocol 5a were supplied

☐ The prescribed substance/s for Protocol 5b were supplied

☐ The prescribed substance/s for Protocol 5c were supplied

Date substance was supplied (DD/MM/YYYY)

Person to whom the voluntary assisted dying substance was supplied

The patient has made a:

- ☐ Self-administration decision

  Person to whom the substance was supplied:

  - ☐ Patient
  - ☐ Contact person for the patient
  - ☐ Agent for the patient

- ☐ Practitioner administration decision

  Person to whom the substance was supplied:

  - ☐ Administering Practitioner for the patient

Details of the person to whom the substance was supplied

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Home/Work address (line 1) _____

Home/Work address (line 2) _____

Suburb _____

State _____ Postcode _____

Is the person's mailing address different to their home/work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1) _____

Mailing address (line 2) _____

Suburb _____

State _____ Postcode _____

Telephone number _____

Email address _____

AHPRA Registration Number (for Registered Health Practitioners only) _____

D. Certifying statements and signature of Authorised Supplier

☐ I, _____ , certify that the prescribed substance was supplied.
Authorised Supplier Name

☐ I, _____ , certify that the requirements under section 73
Authorised Supplier Name
(Labelling requirements for a voluntary assisted dying substance) of the *Voluntary Assisted Dying Act 2019* have been complied with.

When the patient has made a self-administration decision:

☐ I, _____ , certify that the requirements under section 72
Authorised Supplier Name
(Information to be given when supplying a voluntary assisted dying substance) of the *Voluntary Assisted Dying Act 2019* have been complied with.

Signature _____ Date (DD/MM/YYYY) _____

Print name _____

On supply of the prescribed substance, you must:

1. **Immediately complete this form; and,**
2. **Within two business days, give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Practitioner Administration Form

Completed by the Administering Practitioner.

This form (except Part C) is only to be completed by the Administering Practitioner who administers the voluntary assisted dying substance to the patient.

An eligible witness must witness administration of the substance to the patient. This person must complete Part C of this form.

Within **2 business days** after administration of the prescribed substance the Administering Practitioner must:

1. complete this form; and
2. give a copy of the form to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

B. Administering Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State | Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

C. Witness information and certification

A person is ineligible to be a witness if they:

- are under 18 years of age;
- are a family member of the Administering Practitioner; or
- are employed or engaged under a contract for services by the Administering Practitioner.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is your mailing address different to your home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

☐ I, _____ (Witness Name), certify that _____ (Patient Name)'s request for access to voluntary assisted dying appeared to be free, voluntary and enduring.

☐ I, _____ (Witness Name), certify that _____ (Administering Practitioner Name) as Administering Practitioner for _____ (Patient Name) administered the voluntary

assisted dying substance to _____ in my presence.
Patient Name

Signature of witness | Date (DD/MM/YYYY)

D. Details of administration of prescribed substance

Date of administration of prescribed substance (DD/MM/YYYY)

Time of administration of prescribed substance (HH:MM 24 hour clock)

Where did you administer the substance?

- ☐ Public Hospital (ward other than Palliative Care Unit)
- ☐ Private Hospital (ward other than Palliative Care Unit)
- ☐ Hospice or Palliative Care Unit
- ☐ Residential aged care
- ☐ Supported accommodation
- ☐ Patient's home
- ☐ Private residence (e.g. of family or friend of patient)
- ☐ Other (please specify)

E. Patient death

Date of patient death (DD/MM/YYYY)

Time of patient death (HH:MM 24 hour clock)

Time elapsed between administration of prescribed substance to patient and their death (HH:MM)

Were there any complications that occurred relating to the administration of the prescribed substance?

- ☐ No
- ☐ Yes, regurgitation/vomiting
- ☐ Yes, seizure
- ☐ Yes, IV line complications (please specify)
- ☐ Yes, worsening of pain or discomfort
- ☐ Yes, unexpected incontinence
- ☐ Yes, regained consciousness
- ☐ Other (please specify)

F. Signature of Administering Practitioner

☐ I, _____ , am eligible to act as an Administering Practitioner for this
Administering Practitioner Name

patient in accordance with section 54 the *Voluntary Assisted Dying Act 2019*.

I, _____ , certify that:
Administering Practitioner Name

☐ _____ made a practitioner administration decision and did not
Patient Name

revoke the decision.

☐ I am satisfied that at the time of administering the voluntary assisted dying substance to

_____ , that _____ had
Patient Name Patient Name

decision-making capacity in relation to voluntary assisted dying.

☐ I am satisfied that at the time of administering the voluntary assisted dying substance to

_____ , that _____ was
Patient Name Patient Name

acting voluntarily and without coercion.

☐ I am satisfied that at the time of administering the voluntary assisted dying substance to

_____ , that _____ 's
Patient Name Patient Name

request for access to voluntary assisted dying was enduring.

Signature | Date (DD/MM/YYYY)

Print name

Within 2 business days after administration of the prescribed substance you must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Authorised Disposal Form

Completed by the Authorised Disposer.

This form is only to be completed by an Authorised Disposer, as defined in sections 79(3) and 79(4) of the *Voluntary Assisted Dying Act 2019*.

This form is to be completed where the Authorised Disposer has been given the prescribed substance, or a portion of it, by the Contact Person. It is **not** to be completed by an Administering Practitioner who is disposing of the prescribed substance (the Administering Practitioner Disposal Form should be used).

For more information or assistance, an Authorised Disposer can contact the WA VAD Statewide Pharmacy Service.

This form must be completed **immediately** after disposing of a prescribed voluntary assisted dying substance.

Within **2 business days** after disposing of that substance, a copy of the form must be given to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Authorised Disposer information

Unique disposer ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Details of Authorised Disposal

Date substance was given to Authorised Disposer (DD/MM/YYYY)

Date substance was disposed of by Authorised Disposer (DD/MM/YYYY)

Person who gave voluntary assisted dying substance to Authorised Disposer

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the person's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

D. Signature of Authorised Disposer

Signature Date (DD/MM/YYYY)

Print name

On disposal of the prescribed substance, you must:

1. **Immediately complete this form; and,**
2. **Within two business days, give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Administering Practitioner Disposal Form

Completed by the Administering Practitioner.

This form is only to be completed by the Administering Practitioner.

This form is to be completed **immediately** after disposing of a voluntary assisted dying substance.

Refer to the Voluntary Assisted Dying – Prescription and Administration Information for guidelines for disposal.

Within **2 business days** after disposing of the prescribed substance, the Administering Practitioner must give a copy of the form to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Administering Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Details of Authorised Disposal

Date substance was supplied to Administering Practitioner (DD/MM/YYYY)

Date substance was disposed of by Administering Practitioner (DD/MM/YYYY)

Date patient revoked the practitioner administration decision or died (DD/MM/YYYY)

Reason for disposal of voluntary assisted dying substance:

- ☐ Patient revoked practitioner administration decision
- ☐ Patient died via practitioner administration of voluntary assisted dying substance
- ☐ Patient died **not** via practitioner administration of voluntary assisted dying substance

D. Signature of Administering Practitioner

Signature

Date (DD/MM/YYYY)

Print name

On disposal of the prescribed substance, you must:

1. **Immediately complete this form; and,**
2. **Within two business days, give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Notification of Death Form – Coordinating/Administering Practitioner

Completed by the Coordinating or Administering Practitioner.

This form is to be completed by:

- a Coordinating Practitioner, or
- an Administering Practitioner (only when the Administering Practitioner has not already provided the Voluntary Assisted Dying Board with a copy of the Practitioner Administration Form for this patient).

Within **2 business days** of becoming aware that the patient has died (whether by self-administration, practitioner administration or another cause), the Coordinating/Administering Practitioner must:

1. complete this form; and
2. give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Coordinating/Administering Practitioner information

I am the:

- ☐ Coordinating Practitioner for the patient
- ☐ Administering Practitioner for the patient

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

- ☐ No
- ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Patient death

Date of patient death (may be as advised by a third party) (DD/MM/YYYY)

Date Coordinating/Administering Practitioner became aware of patient death (DD/MM/YYYY)

If details of death are known, please select below:

- ☐ Patient self-administered voluntary assisted dying substance
- ☐ Patient did not self-administer voluntary assisted dying substance
- ☐ Unknown

Further details if required

How did you become aware of the patient's death?

- ☐ Contact Person
- ☐ Family member/friend of patient
- ☐ Another registered health practitioner or health care worker
- ☐ Other (please specify)

D. Signature of Coordinating/Administering Practitioner

Signature

Date (DD/MM/YYYY)

Print name

Within 2 business days of becoming aware that the patient has died, the Coordinating/Administering Practitioner must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Notification of Death Form – Other Medical Practitioner

Completed by a medical practitioner attending a deceased person to complete the Medical Certificate Cause of Death.

This form is to be completed by a medical practitioner (who is **not** the Coordinating Practitioner or the Administering Practitioner for the patient) who attended a deceased person to complete the Medical Certificate Cause of Death and who knows or reasonably believes that the person was a patient who self-administered, or was administered, a voluntary assisted dying substance.

NB: the *Voluntary Assisted Dying Act 2019* specifies that no reference to voluntary assisted dying should be included in the Medical Certificate Cause of Death.

Within **2 business days** of the medical practitioner becoming aware that the person has died they must:

1. complete this form; and
2. give a copy to the Voluntary Assisted Dying Board.

A. Deceased person's information

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the deceased person's mailing address different to their home address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Medical practitioner information

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Coordinating Practitioner information (if known)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State

Postcode

Is the Coordinating Practitioner's mailing address different to their work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State

Postcode

Telephone number

Email address

D. Person's death

Date of person's death (DD/MM/YYYY)

Date became aware of person's death (DD/MM/YYYY)

Date of completion of Medical Certificate Cause of Death (DD/MM/YYYY)

☐ I know or reasonably believe that the person self-administered, or was administered, a voluntary assisted dying substance in accordance with the *Voluntary Assisted Dying Act 2019*.

E. Signature of medical practitioner

Signature

Date (DD/MM/YYYY)

Print name

Within 2 business days of becoming aware that the person has died you must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

Voluntary Assisted Dying Board

Revocation Form

Completed by the Coordinating or Administering Practitioner.

This form is only to be completed by the eligible Coordinating Practitioner (in the case of a self-administration decision) or an eligible Administering Practitioner (in the case of a practitioner administration decision) who has successfully completed the approved training within the last 3 years.

This form is to be completed after the patient has informed either the Coordinating Practitioner or the Administering Practitioner of their decision to revoke an administration decision.

Within **2 business days** after the revocation the Coordinating Practitioner or Administering Practitioner (as the case requires) must:

1. complete this form; and
2. give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

B. Practitioner completing this form (either Coordinating or Administering Practitioner)

I am:

- ☐ the Coordinating Practitioner for the patient (do not complete Part C); OR
- ☐ the Administering Practitioner for the patient (complete Part C and inform the Coordinating Practitioner of the revocation)

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State | Postcode

Is your mailing address different to your work address?

- ☐ No
- ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State | Postcode

Telephone number

Email address

C. Coordinating Practitioner information (to be completed by the Administering Practitioner only)

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is the Coordinating Practitioner's mailing address different to their work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

D. Communication

Please indicate the method of communication the patient used to revoke the administration decision:

☐ Spoken language

☐ Sign language (AUSLAN)

☐ Augmentative and alternative communication

☐ Other effective non-spoken communication

☐ In writing

Was the patient assisted by an interpreter when revoking the administration decision?

- ☐ No
- ☐ Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required for the patient?

- ☐ Spoken language other than English
- ☐ Non-spoken communication (e.g. AUSLAN)

Note: *Interpreters must meet* ***all*** *of the criteria below to be an interpreter for this patient under the Act.*

☐ The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

E. Details of revocation decision

Date administration decision was made (DD/MM/YYYY) _____

Date administration decision was revoked (DD/MM/YYYY) _____

If you are the Administering Practitioner, date when you informed the Coordinating Practitioner of the revocation (DD/MM/YYYY) _____

F. Signature of practitioner completing this form

Signature | Date (DD/MM/YYYY)

Print name

Within 2 business days after the revocation the Coordinating Practitioner or Administering Practitioner (as the case requires) must:

1. **complete this form; and**
2. **give a copy to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The revocation of the administration decision.

Voluntary Assisted Dying Board

Coordinating Practitioner Transfer Form

Completed by the original Coordinating Practitioner.

This form is only to be completed by the original Coordinating Practitioner ("Original Practitioner").

The Original Practitioner may transfer the role of Coordinating Practitioner to the Consulting Practitioner if the Consulting Practitioner has assessed the patient as eligible for access to voluntary assisted dying and the Consulting Practitioner accepts the transfer of the role.

NB: the Consulting Practitioner must inform the Original Practitioner whether they accept or refuse transfer of the role within **2 business days** of being requested to accept the transfer.

The Original Practitioner must complete this form after transferring the role of Coordinating Practitioner to the Consulting Practitioner.

Within **2 business days** of the Consulting Practitioner accepting transfer of the role, the Original Practitioner must:

1. complete this form; and
2. give a copy to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Original Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. Consulting Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is the Consulting Practitioner's mailing address different to their work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

D. Details of transfer of Coordinating Practitioner role

Who requested or initiated the transfer of the role?

☐ Patient

☐ Original Practitioner

Date Consulting Practitioner accepted transfer (DD/MM/YYYY)

Date Original Practitioner informed patient of transfer (DD/MM/YYYY)

E. Signature of Original Practitioner

Signature | Date (DD/MM/YYYY)

Print name

Within 2 business days of the transfer being accepted by the Consulting Practitioner, you must:

1. **complete this form, and**
2. **give a copy to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The transfer of Coordinating Practitioner's role

Voluntary Assisted Dying Board

Administering Practitioner Transfer Form

Completed by the original Administering Practitioner.

This form is only to be completed by the original Administering Practitioner ("Original Practitioner").

This form is to be completed if a patient has made a practitioner administration decision, the Coordinating Practitioner has prescribed a voluntary assisted dying substance for the patient, and the Original Practitioner is unable or unwilling to administer the prescribed substance to the patient.

This form is to be completed after transferring the role of Administering Practitioner to another eligible medical practitioner or eligible nurse practitioner (the "New Practitioner").

This New Practitioner must accept the role before the Original Practitioner can transfer the role of Administering Practitioner to them.

Within **2 business days** of the acceptance of the transfer the Original Practitioner must:

1. complete this form; and
2. give a copy of it to the Voluntary Assisted Dying Board.

A. Patient information

Unique patient ID (from VAD-IMS)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Date of birth (DD/MM/YYYY)

Home address (line 1)

Home address (line 2)

Suburb

State Postcode

Is the patient's mailing address different to their home address?

☐ No

☐ Yes

If yes, please complete the fields over the page.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

B. Original Practitioner information

Unique practitioner ID (from VAD-IMS)

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is your mailing address different to your work address?

☐ No

☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

C. New Practitioner information

AHPRA Registration Number

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify)

Family name

Given name

Other given name(s)

Work address (line 1)

Work address (line 2)

Suburb

State Postcode

Is the New Practitioner's mailing address different to their work address? ☐ No ☐ Yes

If yes, please complete the fields below.

Mailing address (line 1)

Mailing address (line 2)

Suburb

State Postcode

Telephone number

Email address

D. Details of Administering Practitioner transfer

☐ I, _____ , have been advised by
Original Practitioner Name

_____ that they are eligible to act as an Administering Practitioner
New Practitioner Name

for the patient and they accept the transfer of the role. *(Refer to Appendix A for practitioner eligibility criteria)*

Date New Practitioner accepted transfer (DD/MM/YYYY)

Date the patient was informed of transfer (DD/MM/YYYY)

☐ I have provided the name and contact details of the New Practitioner to the patient.

If the Original Practitioner has possession of the prescribed substance when the role is transferred, they are authorised to supply it to the New Practitioner and the New Practitioner is authorised to receive it.

E. Signature of Original Administering Practitioner

Signature | Date (DD/MM/YYYY)

Print name

Within 2 business days of the transfer being accepted by the New Practitioner, you must:

1. **complete this form; and**
2. **give a copy of it to the Voluntary Assisted Dying Board.**

You must record the following details in the patient's medical record:

- The transfer of the Administering Practitioner's role.

Voluntary Assisted Dying Board

Administering Practitioner Transfer Form

Completed by the original Administering Practitioner.

Appendix A: Practitioner eligibility criteria

There are eligibility requirements for a practitioner to act in the role of Administering Practitioner as per the *Voluntary Assisted Dying Act 2019* (the Act). These requirements are set out in section 54 of the Act (see extract below). The CEO requirements are outlined in Table 1.

Division 1 – Eligibility requirements for administering practitioners

54. Eligibility to act as administering practitioner

1. A person is eligible to act as an administering practitioner for a patient if –
   a. the person is –
      i. a medical practitioner who is eligible to act as a coordinating practitioner for the patient under section 17(2); or
      ii. a nurse practitioner who has practised the nursing profession for at least 2 years as a nurse practitioner and meets the requirements approved by the CEO for the purposes of this subparagraph;

      and
   b. the person has completed approved training; and
   c. the person is not a family member of the patient; and
   d. the person does not know or believe that they –
      i. are a beneficiary under a will of the patient; or
      ii. may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the administering practitioner for the patient.

Table 1

Section 54(1)(a)(ii) ADMINISTERING PRACTITIONER (nurse practitioner)	
4.1	Nurse practitioner must have clinically practised twice the minimum hours per registration period described in the Recency of Practice Registration Standard published by the Nursing and Midwifery Board of Australia at the advanced practice nursing level as required by the Endorsement as a Nurse Practitioner Registration Standard published by the Nursing and Midwifery Board of Australia, and this clinical practice must include patient assessment and clinical decision making.
4.2	Nurse practitioner must not have any notations, conditions, undertakings or reprimands on their Australian Health Practitioner Regulation Authority (AHPRA) registration record which make the practitioner unsuitable for role under the *Voluntary Assisted Dying Act 2019* as determined by the CEO.
4.3	The CEO must be satisfied as to the suitability of the nurse practitioner for role under the *Voluntary Assisted Dying Act 2019* on the basis of two professional referees provided by the nurse practitioner.

This document can be made available in alternative formats.

Produced by Health Networks

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