



PROPOSED RULE MAKING

CR-102 (June 2004)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Department of Health

- Preproposal Statement of Inquiry was filed as WSR 08-23-089 ; or
- Expedited Rule Making--Proposed notice was filed as WSR _ ; or
- Proposal is exempt under RCW 34.05.310(4).

- Original Notice
- Supplemental Notice to WSR
- Continuance of WSR

Title of rule and other identifying information: (Describe Subject)

Chapter 246-978 WAC, Death with Dignity Act Requirements, creating a new chapter to implement the Washington Death with Dignity Act, Initiative Measure No. 1000.

Hearing location(s): Department of Health
Point Plaza East Rm 152/153
310 Israel Rd SE
Tumwater WA 98501

Date: 02/10/2009

Time: 9:00 am

Submit written comments to:

Name: Carol Wozniak
Address: P.O. Box 47814
Olympia, WA 98504-7814

Website: <http://www3.doh.wa.gov/policyreview/>
fax 360-753-4135 by (date) 02/10/2009

Assistance for persons with disabilities: Contact

Carol Wozniak by 01/27/2009

TTY (800) 833-6388 or () 711

Date of intended adoption: 02/11/2009

(Note: This is **NOT** the **effective** date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The proposed rules are necessary to carry out the Department's responsibility to collect information regarding compliance with Initiative Measure No. 1000 and to define qualifications of witnesses designated by long-term care facilities. The proposed rules clarify definitions, reporting requirements for health care providers, confidentiality of the collected information, and qualifications of a witness for patients in long-term care facilities.

Reasons supporting proposal:

Initiative Measure No. 1000 requires the Department to adopt rules to facilitate the collection of information regarding compliance. Section 15 of this initiative requires the Department to adopt rules to facilitate the collection of information regarding compliance with the Initiative. Section 3 requires the Department to specify in rule the qualifications of the witness designated by a long-term care facility, if the patient is a patient of such a facility.

Statutory authority for adoption:

Initiative Measure No. 1000

Statute being implemented:

Initiative Measure No. 1000

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: January 06, 2009

TIME: 11:06 AM

WSR 09-02-068

DATE 1/06/09

NAME (type or print)

Mary C. Selecky

SIGNATURE

TITLE

Secretary, Department of Health

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

None

Name of proponent: (person or organization) Department of Health

101 Israel Road SE
Tumwater, Washington 98501

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Kara Wagner	101 Israel Road SE, Tumwater, Washington 98501	360-236-4206
Implementation.... Carol Wozniak	101 Israel Road SE, Tumwater, Washington 98501	360-236-4369
Enforcement..... Carol Wozniak	101 Israel Road SE, Tumwater, Washington 98501	360-236-4369

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone

fax

e-mail

No. Explain why no statement was prepared.

A small business economic impact statement was not prepared. The proposed rule would not impose more than minor costs on businesses in an industry.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone

fax

e-mail

No: Please explain: The agency did not complete a cost benefit analysis under RCW 34.05.328. RCW 34.05.328(5)(b)(v) exempts rules the content of which is explicitly and specifically dictated by statute.

Chapter 246-978 WAC

DEATH WITH DIGNITY ACT REQUIREMENTS

NEW SECTION

WAC 246-978-001 Purpose and authority. This chapter is adopted by the Washington state department of health to implement the provisions of Initiative Measure No. 1000, the Washington Death with Dignity Act.

NEW SECTION

WAC 246-978-010 Definitions. For the purpose of this chapter, the following definitions apply:

(1) "Act" means the "Washington Death with Dignity Act" or Initiative Measure No. 1000 as adopted by the voters on November 4, 2008.

(2) "Adult" means an individual who is eighteen years of age or older.

(3) "Attending physician" means the physician, as defined in chapter 18.72 or 18.57 RCW, who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(4) "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating, if those persons are available.

(5) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(6) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

- (7) "Department" means the department of health.
- (8) "Dispensing record" means a copy of the Pharmacy Dispensing Record form, DOH 422-067.
- (9) "Health care facility" means a facility licensed under chapter 70.41, 18.51, or 72.36 RCW.
- (10) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law to administer health care or dispense medication in the ordinary course of business or practice of a profession and includes a health care facility.
- (11) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
- (a) His or her medical diagnosis;
 - (b) His or her prognosis;
 - (c) The potential risks associated with taking the medication to be prescribed;
 - (d) The probable result of taking the medication to be prescribed; and
 - (e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- (12) "Long-term care facility" means a facility licensed under chapter 18.51 or 72.36 RCW.
- (13) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
- (14) "Patient" means a person who is under the care of a physician.
- (15) "Physician" means a doctor of medicine, as defined in chapter 18.71 RCW, or osteopathy, as defined in chapter 18.57 RCW, licensed to practice medicine in the state of Washington.
- (16) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this act in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.
- (17) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.
- (18) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

NEW SECTION

WAC 246-978-020 Reporting. (1) To comply with the act, within thirty calendar days of writing a prescription for medication to end the life of a qualified patient, the attending physician shall send the following completed, signed, and dated documentation by mail to the State Registrar, Center for Health Statistics, P.O. Box 47814, Olympia, WA 98504:

(a) The patient's completed written request for medication to end life, either using the Written Request for Medication to End My Life in a Humane and Dignified Manner form, DOH 422-063, or in substantially the same form as described in the act;

(b) Attending Physician's Compliance form, DOH 422-064;

(c) Consulting Physician's Compliance form, DOH 422-065; and

(d) Psychiatric/Psychological Consultant's Compliance form, DOH 422-066, if an evaluation was performed.

(2) Within thirty calendar days of a qualified patient's ingestion of lethal medication obtained pursuant to the act, or death from any other cause, whichever comes first, the attending physician shall complete the Attending Physician's After Death Reporting form, DOH 422-068.

(3) To comply with the act, within thirty calendar days of dispensing medication, the dispensing health care provider shall file a copy of the Pharmacy Dispensing Record form, DOH 422-067, with the State Registrar, Center for Health Statistics, P.O. Box 47814, Olympia, WA 98504. Information to be reported to the department shall include:

(a) Patient's name and date of birth;

(b) Patient's address;

(c) Prescribing physician's name and phone number;

(d) Dispensing health care provider's name, address and phone number;

(e) Medication dispensed and quantity;

(f) Date the prescription was written; and

(g) Date the medication was dispensed.

NEW SECTION

WAC 246-978-030 Confidentiality--Liability. All information collected by the department under the act shall not be a public record and may not be available for inspection by the public under chapter 42.56 RCW. This information includes, but is not limited to, the identity of patients, health care providers, and health care facilities.

NEW SECTION

WAC 246-978-040 Qualifications of witness in a long-term care facility. If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses must be designated by the long-term care facility. The witness designated by the long-term care facility shall be a person who is not:

- (1) A relative of the patient by blood, marriage, or adoption;
- (2) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law;
- (3) An owner, operator, or employee of a long-term care facility where the qualified patient is receiving medical treatment or is a resident. This witness may be, but is not limited to, an ombudsman, chaplain, or social worker; or
- (4) The patient's attending physician at the time the request is signed.

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.
First Middle Last

I am suffering from _____, which my attending physician has determined is an incurable, irreversible terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and dispense or to contact a pharmacist to dispense the prescription.

Initial One

I have informed my family of my decision and taken their opinions into consideration.

I have decided not to inform my family of my decision.

I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation; and I accept full moral responsibility for my actions.

Signature:	County of Residence:	Date:
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DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1 Witness 2

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is personally known to us or has provided proof of identity; |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Signed this request in our presence on the date following the person's signature; |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Appears to be of sound mind and not under duress, fraud, or undue influence; |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is not a patient for whom either of us is the attending physician. |

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

NOTE: One witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a long-term health care facility, one of the witnesses shall be an individual designated by the facility.



ATTENDING PHYSICIAN'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

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

B	PHYSICIAN INFORMATION	
	NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () —
	MAILING ADDRESS	
	CITY, STATE AND ZIP CODE	

C	ACTION TAKEN TO COMPLY WITH LAW	
	1. FIRST ORAL REQUEST	
	First oral request for medication to end life.	DATE
	Comments:	
	<i>Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)</i>	
	<input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination the patient has six months or less to live. <input type="checkbox"/> 3. Determination that patient is competent.* <input type="checkbox"/> 4. Determination that patient is a Washington state resident.** <input type="checkbox"/> 5. Determination that patient is acting voluntarily. 6. Determination that patient has made his/her decision after being fully informed of:	
	<input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with taking the medication to be prescribed; and <input type="checkbox"/> d) The potential result of taking the medication to be prescribed; and <input type="checkbox"/> e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.	
	<i>Indicate compliance by checking the boxes.</i> <input type="checkbox"/> 1. Patient informed of his or her right to rescind the request at any time. <input type="checkbox"/> 2. Patient recommended to inform next of kin. <input type="checkbox"/> 3. Patient counseled about the importance of having another person present when the patient takes the medication(s). <input type="checkbox"/> 4. Patient counseled about the importance of not taking the medication in a public place.	DATE:
	2. SECOND ORAL REQUEST <i>(Must be made 15 days or more after the first oral request.)</i>	
	<i>Indicate compliance by checking the boxes.</i> <input type="checkbox"/> 1. Second oral request for medication to end life. <input type="checkbox"/> 2. Patient informed of the right to rescind the request at any time.	DATE:
	Comments:	



CONSULTING PHYSICIAN'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:
 State Registrar, Center for Health Statistics,
 P.O. Box 47814, Olympia, WA 98504

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

B	REFERRING/PRESCRIBING PHYSICIAN	
	REFERRING/PRESCRIBING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () —

C	CONSULTANT'S REPORT	
	1. MEDICAL DIAGNOSIS	DATE OF EXAMINATION(S)
	2. Check boxes for compliance. <i>(Both the attending and consulting physicians must make these determinations.)</i> <input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination the patient has 6 months or less to live. <input type="checkbox"/> 3. Determination that patient is competent.* <input type="checkbox"/> 4. Determination that patient is acting voluntarily. 5. Determination that patient has made his/her decision after being fully informed of: <input type="checkbox"/> a. His or her medical diagnosis; and <input type="checkbox"/> b. His or her prognosis; and <input type="checkbox"/> c. The potential risks associated with taking the medication to be prescribed; and <input type="checkbox"/> d. The potential result of taking the medication to be prescribed; and <input type="checkbox"/> e. The feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control. Comments:	

D	PATIENT'S MENTAL STATUS		
	Check one of the following (required) : <input type="checkbox"/> I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with Initiative Measure No. 1000 (codified as RCW XXX). <input type="checkbox"/> I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.		
	PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER () —	DATE

E	CONSULTANT'S INFORMATION		
	X	PHYSICIAN'S SIGNATURE	DATE
		NAME (PLEASE PRINT)	
	MAILING ADDRESS		
	CITY, STATE AND ZIP CODE		TELEPHONE NUMBER () —

* "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.



PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

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

B REFERRING/PRESCRIBING PHYSICIAN	
REFERRING PHYSICIAN'S NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: () —

C PSYCHIATRIC / PSYCHOLOGICAL EVALUATION	
1. MEDICAL DIAGNOSIS	DATE(S) OF EXAMINATION(S):
2. PSYCHIATRIC / PSYCHOLOGICAL EVALUATION	

D PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION	
I have determined through evaluation that the above-named patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment, in conformance with Initiative Measure No. 1000 (codified as RCW XXX).	
	CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):
	CONSULTANT'S NAME (PRINTED):
MAILING ADDRESS:	
CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: () —



PHARMACY DISPENSING RECORD

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

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

B	PHYSICIAN INFORMATION	
	NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: () —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	

C	DISPENSING HEALTH CARE PROVIDER INFORMATION	
	NAME (LAST, FIRST, M.I.) AND TITLE:	TELEPHONE NUMBER: () —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	DATE OF THIS REPORT:

D	MEDICATIONS DISPENSED			
	MEDICATIONS	QUANTITY	DATE PRESCRIBED	DATE DISPENSED
	#1			
	#2			
	#3			
	#4			

E	SIGNATURE		
	DISPENSING HEALTH CARE PROVIDER'S SIGNATURE	TELEPHONE NUMBER () —	DATE



ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47814, Olympia, WA 98504

Dear Physician:

The Washington Death with Dignity Act requires physicians who write a prescription for lethal medications under the Act to report to the Department of Health information that documents compliance with the law. The attending physician shall complete this form within thirty calendar days of a patient's ingestion of lethal medication obtained pursuant to the act or death from any other cause, whichever comes first. If you do not know the answers to any of the following questions, please contact the family or patient's representative.

All individual information will be kept strictly confidential. Aggregate information will be provided on an annual basis. If you have questions about these instructions, please call 360-236-4369.

Physician's Name: _____

Date: ___/___/___

Patient Name: _____

Date of Patient's Death: ___/___/___

1. Did the patient die from the ingestion of lethal medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

If the patient died from ingestion of a lethal medication complete questions 2-23.

If the patient died from their underlying illness or other causes do not complete questions 2-23. Mail this page, along with a separate slip of paper with your name and the patient's name to the address listed above. Any medication dispensed that was not self-administered shall be disposed of by lawful means.

- 1 Ingestion of lethal medication
- 2 Underlying illness
- 3 Other (specify): _____

2. On what date did you begin caring for this patient?

___/___/___ (Mo/Da/Yr)

3. On what date was the patient first told about their underlying medical condition?

___/___/___ (Mo/Da/Yr)

4. On what date was the patient told they have a terminal disease – meaning an incurable and irreversible disease that will within reasonable medical judgment produce death within six months?

___/___/___ (Mo/Da/Yr)

5. On what date was the lethal prescription written or phoned in?

___/___/___ (Mo/Da/Yr)

6. And, on what date were the lethal medications dispensed to the patient?

___/___/___ (Mo/Da/Yr) . Not Dispensed Unknown

7. Were you at the patient's bedside when the patient took the lethal medication?

- 1 Yes
- 2 No, did not offer to be present at the time of ingestion
- 3 No, offered to be present, but the patient declined
- 8 No, other (specify): _____
- 9 Unknown

If no: Was another physician or trained health care provider or volunteer present when the patient ingested medication?

- 1 Yes, another physician
- 2 Yes, a trained health-care provider/volunteer (specify): _____
- 3 No
- 9 Unknown

8. Were you at the patient's bedside at the time of death?

- 1 Yes
- 2 No

If no: Was another physician or trained health care provider or volunteer present at the patient's time of death?

- 1 Yes, another physician
- 2 Yes, a trained health-care provider/volunteer
- 3 No
- 9 Unknown

If no: How were you informed of the patient's death?

- 1 Family member called M.D.
- 2 Friend of patient called M.D.
- 3 Another physician
- 4 Hospice R.N.
- 5 Hospital R.N.
- 6 Nursing home/Assisted-living staff
- 7 Funeral home
- 8 Medical Examiner
- 9 Other (specify): _____

9. What lethal medication was prescribed and what was the dosage?

10. Did the patient take the lethal medications according to the prescription directions?

- 1 Yes
- 2 No

If no: Please list the medications the patient took (other than those reported in item 9), the dosages, and the reason for not following the prescription directions.

9 Unknown

11. Were there any complications after the lethal medication ingestion, for example, vomiting, seizures, or regaining consciousness?

1 Yes

Please Describe:

2 No

9 Unknown

12. Was the Emergency Medical System activated for any reason after the ingestion of the lethal medications?

1 Yes

Please describe:

2 No

9 Unknown

13. What was the time between lethal medication ingestion and unconsciousness?

Minutes: _____ or Hours: _____ Unknown

14. What was the time between lethal medication ingestion and death?

Minutes: _____ or Hours: _____ Unknown

If the patient lived longer than six hours:

Do you have any observations on why the patient lived for more than six hours after ingesting the medication? _____

15. Seven possible concerns that may have contributed to the patient's decision to request a prescription for lethal medication are shown below. Please check "Yes," "No," or "Don't know," depending on whether or not you believe that concern contributed to the request.

A concern about:

...the financial cost of treating or prolonging his or her terminal condition.

Yes No Don't Know

...the physical or emotional burden on family, friends, or caregivers.

Yes No Don't Know

...his or her terminal condition representing a steady loss of autonomy.

Yes No Don't Know

...the decreasing ability to participate in activities that made life enjoyable.

Yes No Don't Know

...the loss of control of bodily functions, such as incontinence and vomiting.

Yes No Don't Know

...inadequate pain control at the end of life.

Yes No Don't Know

...a loss of dignity.

Yes No Don't Know

16. Immediately prior to ingestion of lethal medication, what was the patient's mobility? (ECOG scale)

0 Fully active, no restrictions on pre-disease performance.

1 Restricted in strenuous activity, but ambulatory and able to carry out work.

2 Ambulatory and capable of all self-care, but no work activities; up and about more than 50% of waking hours.

3 Capable of only limited self-care; in bed or chair more than 50% of waking hours.

4 Completely disabled, no self-care, totally confined to bed or chair.

9 Unknown

17. Where did the patient ingest the medication?

1 Private home

2 Assisted-living residence (including foster care)

3 Nursing home

4 Acute care hospital in-patient

5 In-patient hospice resident

6 Other (specify) _____

9 Unknown

18. When the patient initially requested a prescription for the lethal medication, was the patient receiving hospice care?

1 Yes

2 No, refused care

3 No, never offered care

4 No, other (specify) _____

9 Unknown

19. At the time of ingestion of the lethal medication, was the patient receiving hospice care?

- 1 Yes
- 2 No, refused care
- 3 No, never offered care
- 4 No, other (specify) _____
- 9 Unknown

20. What type of health-care coverage did the patient have for their underlying illness? (Check all that apply.)

- 1 Medicare
- 2 Medicaid
- 3 Military/CHAMPUS
- 4 V.A.
- 5 Indian Health Service
- 6 Private insurance
- 7 No insurance
- 8 Had insurance, don't know type
- 9 Unknown

21. What is your medical specialty? (Check all that apply.)

- 1 Family Practice
- 2 Internal Medicine
- 3 Oncology
- 4 Other (specify) _____

22. How many years have you been in practice, not including any training periods, such as residency or fellowship?

Years: _____

23. And lastly, do you have any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

FOR OFFICIAL USE ONLY

CASE ID NUMBER:

DWDA

ILLNESS

PHYSICIAN ID
NUMBER: