ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ILLINOIS END-OF-LIFE OPTIONS FOR TERMINALLY ILL PATIENTS ACT FOLLOW-UP FORM

INSTRUCTIONS

This form must be submitted by the attending physician to the Illinois Department of Public Health within 60 calendar days of being notified of a patient's death from self-administering medication prescribed under the Act. PA 104-0441 , 410 ILCS 22

ATTENDING PHYSICIAN INFORMATION

First Name _____ Last Name _____

IL Medical License # _____ Expiration _____

Mailing Address _____ Email _____

City _____ State, Zip Code _____ Phone Number _____

PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____

Date of Patient Death _____ Patient DOB _____

Patient enrolled in hospice at the time of death?

◯ Yes

◯ No

ATTESTATION

I, _____ (Physician Name), verify that I am a licensed physician in good standing in the State of Illinois.

_____ (Patient Name).

In accordance with the requirements of this Act, I have been notified of the death of this patient following self-administration of medication that I prescribed for this purpose under the Act.

Signature _____ Date _____

SUBMIT TO IDPH

EMAIL: DPH.EOL@illinois.gov

MAIL: EOL PROGRAM

525 W JEFFERSON ST, 2ND FLOOR • SPRINGFIELD, IL 62761

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH