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CONTENTS

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STATE GOVERNMENT INSTRUMENTS

VOLUNTARY ASSISTED DYING REGULATIONS 2022

REGULATIONS 4 TO 11, 14, 15, 17 AND 19

Determination of Prescribed Forms

I, CHRIS PICTON, Minister for Health and Wellbeing, hereby determine:

- the First Assessment Report Form in Schedule 1 as the prescribed form for the purposes of regulation 8 of the Regulations;
- the Consulting Assessment Report Form in Schedule 2 as the prescribed form for the purposes of regulation 4 of the *Voluntary Assisted Dying Regulations 2022* (the Regulations);
- the Written Declaration in Schedule 3 as the prescribed form for the purposes of regulation 11 of the Regulations;
- the Contact Person Appointment Form in Schedule 4 as the prescribed form for the purposes of regulation 5 of the Regulations;
- the Final Review Form in Schedule 5 as the prescribed form for the purposes of regulation 7 of the Regulations;
- the Application for Practitioner Administration Permit in Schedule 6 as the prescribed form for the purposes of regulation 15 of the Regulations;
- the Application for Self Administration Permit in Schedule 7 as the prescribed form for the purposes of regulation 14 of the Regulations;
- the Voluntary Assisted Dying Permit in Schedule 8 as the prescribed form for the purposes of regulation 17 of the Regulations;
- the Labeling Requirements for Voluntary Assisted Dying Substance in Schedule 9 as the prescribed form for the purposes of regulation 19 of the Regulations.
- the Voluntary Assisted Dying Substance Dispensing Form in Schedule 10 as the prescribed form for the purposes of regulation 9 of the Regulations;
- the Coordinating Medical Practitioner Administration Form in Schedule 11 as the prescribed form for the purposes of regulation 6 of the Regulations;
- the Voluntary Assisted Dying Substance Disposal Form in Schedule 12 as the prescribed form for the purposes of regulation 10 of the Regulations;

Dated: 24 January 2023

HON CHRIS PICTON MP
Minister for Health and Wellbeing

SCHEDULE 1

Voluntary Assisted Dying

First assessment report form

Coordinating Medical Practitioners complete this form to record the outcome of a first assessment for access to voluntary assisted dying.

Coordinating Medical Practitioners must:

- Assess the patient's eligibility to access voluntary assisted dying.
- Make a referral for a specialist opinion if you're uncertain of a patient's eligibility, or if they have a neurodegenerative condition with a prognosis of more than 6 months.
- Submit this form within 7 calendar days of completing the first assessment.

If you assess the person as eligible to access voluntary assisted dying you must make a referral to another registered medical practitioner for a consulting assessment.

For more information about the First request read the Voluntary assisted dying clinical guideline at www.sahealth.sa.gov.au/vad.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Medicare number: _____ Medicare individual reference no: _____

Phone: _____ ☐ No phone

Email: _____

Does the patient want to receive email updates about their request to access voluntary assisted dying? ☐ Yes ☐ No

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Patient Demographics

The below questions help the Voluntary Assisted Dying Review Board:

- understand who is accessing voluntary assisted dying
- improve the quality and safety of voluntary assisted dying in South Australia.

These questions are optional. Answering these questions doesn't affect your eligibility to access voluntary assisted dying.

Do you need support from an interpreter? ☐ Yes ☐ No

Interpreter language: _____

Interpreter type:

☐ Any interpreter

☐ Male interpreter

☐ Female interpreter

Gender:

☐ Male

☐ Female

☐ Nonbinary

☐ Prefer not to say

☐ I use a different term _____

Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander
- ☐ Prefer not to say

Country of birth: _____ Preferred language: _____

Highest level of education:

- ☐ Years 9 and below
- ☐ Certificate I & II
- ☐ Secondary education – Years 10 and above
- ☐ Certificate III & IV
- ☐ Advanced Diploma and Diploma
- ☐ Bachelor Degree
- ☐ Graduate Diploma or Graduate Certificate
- ☐ Postgraduate degree
- ☐ Prefer not to say
- ☐ Other

Living arrangement:

- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with others
- ☐ Prefer not to say

Residential setting:

- ☐ House, flat or other private residence
- ☐ Retirement village
- ☐ Residential aged care facility
- ☐ Supported residential facilities
- ☐ Specialist disability accommodation
- ☐ Palliative care facility/ hospice
- ☐ Hospital
- ☐ Psychiatric hospital
- ☐ Specialised mental health community based residential support service
- ☐ Specialised alcohol/other drug treatment service
- ☐ Homelessness shelter / emergency accommodation
- ☐ Homeless
- ☐ Correctional services facility
- ☐ Other accommodation
- ☐ Prefer not to say
- ☐ Other _____

B Coordinating practitioner information

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Coordinating practitioner eligibility

Do you have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person? ☐ Yes ☐ No

Have you practised as a registered medical practitioner for at least 5 years after completing a fellowship with a specialist medical college or vocational registration? ☐ Yes ☐ No

Are you a family member of the person? ☐ Yes ☐ No

Do you know or have reasonable grounds to believe that you either:

- may be a beneficiary under a will of the person; or
- may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the person).

☐ Yes ☐ No

How long have you been providing care for this patient?

☐ No previous relationship

☐ Less than 12 months

☐ 1-2 years

☐ 2-5 years

☐ 5-10 years

☐ More than 10 years

C Criteria for access to voluntary assisted dying

Date first request made (DD/MM/YYYY): _____

In relation to the criteria for access to voluntary assisted dying, I have decided that the patient:

Has reached 18 years of age	☐ Yes	☐ No
Is an Australian citizen or permanent resident	☐ Yes	☐ No
At the time of making the First Request has been ordinarily resident in South Australia for at least 12 months	☐ Yes	☐ No
Has decision-making capacity in relation to voluntary assisted dying	☐ Yes	☐ No

Has been diagnosed with a disease, illness or medical condition that meets all the below criteria:

• Is incurable	☐ Yes	☐ No
• Is advanced, progressive and will cause death	☐ Yes	☐ No
• Is expected to cause death within a period of 6 months, or 12 months if it's a neurodegenerative disease, illness or medical condition	☐ Yes	☐ No
• Is causing suffering to the patient that cannot be relieved in a manner that the patient considers tolerable	☐ Yes	☐ No
Is acting voluntarily and without coercion	☐ Yes	☐ No
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

Patient's diagnosis

Primary diagnosis: _____

Secondary diagnosis(es): _____

Additional commentary: _____

D Referral for specialist opinion

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

☐ No (Go to Part E)

☐ Yes (please complete Appendix A for each referral made)

E Palliative care and treatment options

This section captures what palliative care and treatment options are available to the person. These questions don't affect the person's eligibility to access voluntary assisted dying.

If a person is eligible to access voluntary assisted dying, then their Coordinating Medical Practitioner must inform them about available treatment options and palliative care options.

You can find information about Palliative care services in South Australia at www.sahealth.sa.gov.au

Is the patient currently receiving specialist palliative care?

☐ No

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

☐ Yes

If yes, from where are they receiving palliative care?

☐ Outpatient clinic

☐ Community or home-based palliative care

☐ Consultation in a facility

☐ Consultation in a hospital

☐ Specialist Palliative Care Unit

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

F Communication during First Assessment

Interpreter details

If the patient was assisted by an interpreter during the First Assessment, complete this section. Otherwise, leave this section blank.

What type of interpreter service was required for the patient?

☐ Any interpreter ☐ Male interpreter

☐ Female interpreter ☐ Other body prescribed by the Minister

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____ Email: _____

NAATI Practitioner number: _____

Has the interpreter confirmed that, to the best of their knowledge, they're eligible to act as an interpreter in line with the *Voluntary Assisted Dying Act 2021 (SA)*? ☐ Yes ☐ No

The Act requires interpreters to meet all the below criteria:

- they're accredited with the National Accreditation Authority for Translators and Interpreters (NAATI)
- they aren't a family member of the person
- they don't know or believe they may benefit from the death of the person
- they don't own, or are responsible for the day-to-day management of a health facility where the person lives or is being treated
- they aren't directly involved in providing health or professional care services to the person.

G Information to be provided

If patient meets criteria for access to voluntary assisted dying

If the patient is assessed as meeting the criteria to access voluntary assisted dying (Part C) you must inform them about all the below:

- their diagnosis and prognosis
- their options for treatment and care, their risks, and the likely outcomes of that care, including palliative care options
- the effects, potential risks, and outcome of taking the voluntary assisted dying medication, if they decide to take it
- that the expected outcome of taking the voluntary assisted dying medication is death
- that the person can withdraw from the voluntary assisted dying process at any time
- the benefits of informing any other medical practitioner that they receive care from about their decision to access to voluntary assisted dying.

If the person does not understand the above information, you must assess them as not eligible to access voluntary assisted dying.

Does the patient understand the above information?

☐ No

☐ Yes

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

☐ No

☐ Yes

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

☐ Yes

☐ No (please complete Appendix B)

H Outcome of First Assessment

You must assess the patient as eligible for access to voluntary assisted dying if the you are satisfied that both the below criteria are met:

- The patient meets all of the eligibility criteria to access voluntary assisted dying (Part C)
- The patient understands the information required to be provided to eligible patients (Part G)

If you're not satisfied that both the above criteria are met, you 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 First Assessment completion (DD/MM/YYYY): _____

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

Signature

By signing this form you are stating you understand and agree to all the below terms:

- I confirm the information I have provided is true and correct.
- I confirm that, to the best of my knowledge, I am eligible to act as a Coordinating Medical Practitioner for the person in line with the Voluntary Assisted Dying Act 2021 (SA).
- I understand that if I have assessed the patient as eligible, I must refer them to another registered medical practitioner for a consulting assessment.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #:

Form reference #:

Episode reference #:

Practitioner VAD ID #:

SCHEDULE 2

Voluntary Assisted Dying

Consulting assessment report form

Consulting Medical Practitioners complete this form to record the outcome of a consulting assessment for access to voluntary assisted dying.

Consulting Medical Practitioners must:

- Independently assess the patient's eligibility to access voluntary assisted dying.
- Make a referral for a specialist opinion if you're uncertain of a patient's eligibility, or if they have a neurodegenerative condition with a prognosis of more than 6 months.
- Submit this form within 7 calendar days of completing the consulting assessment.

For more information about the Consulting assessment read the Voluntary assisted dying clinical guideline at www.sahealth.sa.gov.au/vad.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Medicare number: _____ Medicare individual reference no: _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Patient Demographics

The below questions help the Voluntary Assisted Dying Review Board:

- understand who is accessing voluntary assisted dying
- improve the quality and safety of voluntary assisted dying in South Australia.

These questions are optional. Answering these questions doesn't affect your eligibility to access voluntary assisted dying.

Do you need support from an interpreter? ☐ Yes ☐ No

Interpreter language: _____

Interpreter type:

☐ Any interpreter

☐ Male interpreter

☐ Female interpreter

Gender:

☐ Male

☐ Female

☐ Nonbinary

☐ Prefer not to say

☐ I use a different term _____

Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander
- ☐ Prefer not to say

Country of birth: _____ Preferred language: _____

Highest level of education:

- ☐ Years 9 and below
- ☐ Certificate I & II
- ☐ Secondary education – Years 10 and above
- ☐ Certificate III & IV
- ☐ Advanced Diploma and Diploma
- ☐ Bachelor Degree
- ☐ Graduate Diploma or Graduate Certificate
- ☐ Postgraduate degree
- ☐ Prefer not to say
- ☐ Other

Living arrangement:

- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with others
- ☐ Prefer not to say

Residential setting:

- ☐ House, flat or other private residence
- ☐ Retirement village
- ☐ Residential aged care facility
- ☐ Supported residential facilities
- ☐ Specialist disability accommodation
- ☐ Palliative care facility/ hospice
- ☐ Hospital
- ☐ Psychiatric hospital
- ☐ Specialised mental health community based residential support service
- ☐ Specialised alcohol/other drug treatment service
- ☐ Homelessness shelter / emergency accommodation
- ☐ Homeless
- ☐ Correctional services facility
- ☐ Other accommodation
- ☐ Prefer not to say
- ☐ Other _____

B Consulting practitioner information

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Consulting practitioner eligibility

Do you have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person? ☐ Yes ☐ No

Have you practised as a registered medical practitioner for at least 5 years after completing a fellowship with a specialist medical college or vocational registration? ☐ Yes ☐ No

Are you a family member of the person? ☐ Yes ☐ No

Do you know or have reasonable grounds to believe that you either:

- may be a beneficiary under a will of the person; or
- may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services as the Coordinating Practitioner or Consulting Practitioner for the person).

☐ Yes ☐ No

How long have you been providing care for this patient?

☐ No previous relationship

☐ Less than 12 months

☐ 1-2 years

☐ 2-5 years

☐ 5-10 years

☐ More than 10 years

C Criteria for access to voluntary assisted dying

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 criteria for access to voluntary assisted dying, I have decided that the patient:

Has reached 18 years of age	☐ Yes	☐ No
Is an Australian citizen or permanent resident	☐ Yes	☐ No
At the time of making the First Request has been ordinarily resident in South Australia for at least 12 months	☐ Yes	☐ No
Has decision-making capacity in relation to voluntary assisted dying	☐ Yes	☐ No

Has been diagnosed with a disease, illness or medical condition that meets all the below criteria:

• Is incurable	☐ Yes	☐ No
• Is advanced, progressive and will cause death	☐ Yes	☐ No
• Is expected to cause death within a period of 6 months, or 12 months if it's a neurodegenerative disease, illness or medical condition	☐ Yes	☐ No
• Is causing suffering to the patient that cannot be relieved in a manner that the patient considers tolerable	☐ Yes	☐ No
Is acting voluntarily and without coercion	☐ Yes	☐ No
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

Patient's diagnosis

Primary diagnosis: _____

Secondary diagnosis(es):

Additional commentary:

D Referral for specialist opinion

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

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

E Palliative care and treatment options

This section captures what palliative care and treatment options are available to the person. These questions don't affect the person's eligibility to access voluntary assisted dying.

If a person is eligible to access voluntary assisted dying, then their Coordinating Medical Practitioner must inform them about available treatment options and palliative care options.

You can find information about Palliative care services in South Australia at www.sahealth.sa.gov.au

Is the patient currently receiving specialist palliative care?

☐ No

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

☐ Yes

If yes, from where are they receiving palliative care?

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

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

F Communication during Consulting Assessment

Interpreter details

If the patient was assisted by an interpreter during the Consulting Assessment, complete this section. Otherwise, leave this section blank.

What type of interpreter service was required for the patient?

☐ Any interpreter ☐ Male interpreter

☐ Female interpreter ☐ Other body prescribed by the Minister

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____ Email: _____

NAATI Practitioner number: _____

Has the interpreter confirmed that, to the best of their knowledge, they're eligible to act as an interpreter in line with the *Voluntary Assisted Dying Act 2021 (SA)*? ☐ Yes ☐ No

The Act requires interpreters to meet all the below criteria:

- they're accredited with the National Accreditation Authority for Translators and Interpreters (NAATI)
- they aren't a family member of the person
- they don't know or believe they may benefit from the death of the person
- they don't own, or are responsible for the day-to-day management of a health facility where the person lives or is being treated
- they aren't directly involved in providing health or professional care services to the person.

G Information to be provided

If patient meets criteria for access to voluntary assisted dying

If the patient is assessed as meeting the criteria to access voluntary assisted dying (Part C) you must inform them about all the below:

- their diagnosis and prognosis
- their options for treatment and care, their risks, and the likely outcomes of that care, including palliative care options
- the effects, potential risks, and outcome of taking the voluntary assisted dying medication, if they decide to take it
- that the expected outcome of taking the voluntary assisted dying medication is death
- that the person can withdraw from the voluntary assisted dying process at any time
- the benefits of informing any other medical practitioner that they receive care from about their decision to access to voluntary assisted dying.

If the person does not understand the above information, you must assess them as not eligible to access voluntary assisted dying.

Does the patient understand the above information?

☐ No

☐ Yes

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

☐ No

☐ Yes

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

☐ Yes

☐ No (please complete Appendix B)

H Outcome of Consulting Assessment

You must assess the patient as eligible for access to voluntary assisted dying if the you are satisfied that both the below criteria are met:

- The patient meets all of the eligibility criteria to access voluntary assisted dying (Part C)
- The patient understands the information required to be provided to eligible patients (Part G)

If you're not satisfied that both the above criteria are met, you 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): _____

Signature

By signing this form you are stating you understand and agree to all the below terms:

- I confirm the information I have provided is true and correct.
- I confirm that, to the best of my knowledge, I am eligible to act as a Consulting Medical Practitioner for the person in line with the Voluntary Assisted Dying Act 2021 (SA).
- I understand that if I have assessed the patient as eligible, I must refer them to another registered medical practitioner for a consulting assessment.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #:

Form reference #:

Episode reference #:

Practitioner VAD ID #:

SCHEDULE 3

Voluntary Assisted Dying

Written declaration form

Complete this form to record your written request to access voluntary assisted dying.

You must sign this form in the presence of 2 witnesses and your coordinating practitioner.

If you are unable to complete this form yourself, another person can complete this form on your behalf. You can also get help from an interpreter.

Give the completed form to your coordinating medical practitioner. They submit it in the Voluntary Assisted Dying Clinical Portal.

For more information about the First request read the Voluntary assisted dying clinical guideline at www.sahealth.sa.gov.au/vad.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Person details

VAD Portal Patient ID: _____

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Person declaration

If the person can complete this form themselves, they complete this section. Otherwise, leave this section blank.

By signing this form you're stating you understand and agree to all the below terms:

- I request access to voluntary assisted dying.
- I make this request voluntarily and without coercion.
- I understand the nature and effect of this request being that if I meet the requirements of the Voluntary Assisted Dying Act 2021 I will be prescribed a voluntary assisted dying medication, and I expect to die when I self-administer or I am administered that medication.
- I'm signing this declaration in the presence of 2 witnesses and the coordinating medical practitioner.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Declaration on behalf of the person

If the person is unable to complete this form themselves, another person completes this section on the person's behalf. Otherwise, leave this section blank.

By signing this form, you're stating you understand and agree to all the below terms:

- The person is unable to sign this declaration themselves.
- The person has expressly directed me to sign the declaration on their behalf.
- I'm not a witness to this declaration or the coordinating or consulting medical practitioner for the person.
- I'm aged 18 years or older.
- I'm signing this declaration in the presence of the person, two witnesses and the coordinating medical practitioner.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

B Coordinating practitioner information

Ahpra number: _____ VAD Portal Practitioner ID: _____

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Interpreter details

If an interpreter helped the person make the Written Declaration, they complete this section. Otherwise, leave this section blank.

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____ Email: _____

NAATI Practitioner number: _____

Has the interpreter confirmed that, to the best of their knowledge, they're eligible to act as an interpreter in line with the *Voluntary Assisted Dying Act 2021 (SA)*? ☐ Yes ☐ No

The Act requires interpreters to meet all the below criteria:

- they're accredited with the National Accreditation Authority for Translators and Interpreters (NAATI)
- they aren't a family member of the person
- they don't know or believe they may benefit from the death of the person
- they don't own, or are responsible for the day-to-day management of a health facility where the person lives or is being treated
- they aren't directly involved in providing health or professional care services to the person.

D Witness to signing of declaration

First witness

By signing this form, you're stating you understand and agree to all the below terms:

- To the best of my knowledge, I am eligible to act as a witness in line with the *Voluntary Assisted Dying Act 2021 (SA)*.
- The person, or another person on their acting on their behalf, signed this declaration in my presence and the presence of another witness, the person and the coordinating medical practitioner.
- The person appears to be making this declaration freely and voluntarily.
- The person appears to have decision making capacity in relation to voluntary assisted dying.
- The person appears to understand the nature and effect of making this declaration.
- I am signing this declaration in the presence of the coordinating medical practitioner.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Second witness

By signing this form, you're stating you understand and agree to all the below terms:

- To the best of my knowledge, I am eligible to act as a witness in line with the *Voluntary Assisted Dying Act 2021 (SA)*.
- The person, or another person on their acting on their behalf, signed this declaration in my presence and the presence of another witness, the person and the coordinating medical practitioner.
- The person appears to be making this declaration freely and voluntarily.
- The person appears to have decision making capacity in relation to voluntary assisted dying.
- The person appears to understand the nature and effect of making this declaration.
- I am signing this declaration in the presence of the coordinating medical practitioner.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #: Episode reference #:

Form reference #: Practitioner VAD ID #:

SCHEDULE 4

Voluntary Assisted Dying

Contact person appointment form

Complete this form to appoint a contact person who agrees to be responsible for returning any unused voluntary assisted dying medication to the pharmacy.

You and the contact person both sign this form in the presence of each other and a witness.

If you can't complete this form yourself, another person can complete this form on your behalf. You can also get help from an interpreter.

Give the completed form to your Coordinating Medical Practitioner. They submit the form to the Voluntary Assisted Dying Review Board.

For more information about the Contact Person Appointment read the Voluntary assisted dying clinical guideline at www.sahealth.sa.gov.au/vad.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Person details

VAD Portal Patient ID: _____

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Person declaration

If the person can complete this form themselves, they complete this section. Otherwise, leave this section blank.

By signing this form you're stating you understand and agree to all the below terms:

- I nominate the person named on this form to be my contact person.
- To the best of my understanding, the person is eligible to act as a contact person in line with the *Voluntary Assisted Dying Act 2021 (SA)*.
- To the best of my understanding, the person understands and accepts the responsibilities of being my contact person as set out in the *Voluntary Assisted Dying Act 2021 (SA)*.
- I'm signing this form in the presence of the contact person and a witness.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Declaration on behalf of the person

If the person is unable to complete this form themselves, another person completes this section on the person's behalf. Otherwise, leave this section blank.

By signing this form, you're stating you understand and agree to all the below terms:

- The person is unable to sign the declaration themselves.
- The person has expressly directed me to sign the declaration on their behalf.
- I'm not a witness to this declaration or the contact person.
- I'm aged 18 years or older.
- I am signing this declaration in the presence of the person, the contact person and a witness.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

B Coordinating practitioner information

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Contact person information

Family name: _____

First name: _____

Other given name(s): _____

Date of Birth (DD/MM/YYYY): _____

Telephone number: _____

Email address: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

Contact person declaration

By signing this form you're stating you understand and agree to all the below terms:

- I agree to be the contact person for the person.
- To the best of my knowledge, I am eligible to act as a contact person in line with the *Voluntary Assisted Dying Act 2021 (SA)*.
- I understand the requirements of my role under the *Voluntary Assisted Dying Act 2021 (SA)*.
- I'm signing this form in the presence of the person, or another person on their acting on their behalf, and a witness.
- I'm signing this form in the presence of the contact person and a witness.
- I understand the personal information I've provided will be used by the Voluntary Assisted Dying Pharmacy Service to contact me after the person's death.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Witness details

By signing this form, you're stating you understand and agree to all the below terms:

- I confirm that, to the best of my knowledge, I am eligible to act as a witness in line with the *Voluntary Assisted Dying Act 2021 (SA)*.
- I confirm that the person, or another person on their acting on their behalf, and the contact person signed this declaration in my presence.
- I am signing this form in the presence of the contact person and a witness.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

D Interpreter details

If an interpreter helped the person complete this form, they complete this section.
Otherwise, leave this section blank.

What type of interpreter service was required for the patient?

- ☐ Any interpreter
- ☐ Male interpreter
- ☐ Female interpreter
- ☐ Other body prescribed by the Minister

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____ Email: _____

NAATI Practitioner number: _____

Has the interpreter confirmed that, to the best of their knowledge, they're eligible to act as an interpreter in line with the *Voluntary Assisted Dying Act 2021 (SA)*? ☐ Yes ☐ No

The Act requires interpreters to meet all the below criteria:

- they're accredited with the National Accreditation Authority for Translators and Interpreters (NAATI)
- they aren't a family member of the person
- they don't know or believe they may benefit from the death of the person
- they don't own, or are responsible for the day-to-day management of a health facility where the person lives or is being treated
- they aren't directly involved in providing health or professional care services to the person.

Administrative use only

Patient reference #: Episode reference #:

Form reference #: Practitioner VAD ID #:

SCHEDULE 5

Voluntary Assisted Dying

Final review form

Coordinating Medical Practitioners complete this form to:

- record a patient's final request for access to voluntary assisted dying
- confirm that the request and assessment process has been completed in line with the Voluntary Assisted Dying Act (SA) 2021.

Coordinating Medical Practitioners must review all the below forms before submitting this form:

- First assessment report form
- all Consulting assessment report forms
- the Written declaration
- the Contact person appointment form.

Submit this form within 7 days of completing this form.

For more information about the Final assessment read the Voluntary assisted dying clinical guideline at www.sahealth.sa.gov.au/vad.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Medicare number: _____ Medicare individual reference no: _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Coordinating Practitioner information

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Communication

Interpreter details

If the patient was assisted by an interpreter during the Final Request, complete this section. Otherwise, leave this section blank.

What type of interpreter service was required for the patient?

☐ Any interpreter ☐ Male interpreter

☐ Female interpreter ☐ Other body prescribed by the Minister

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____ Email: _____

NAATI Practitioner number: _____

Has the interpreter confirmed that, to the best of their knowledge, they're eligible to act as an interpreter in line with the *Voluntary Assisted Dying Act 2021 (SA)*? ☐ Yes ☐ No

The Act requires interpreters to meet all the below criteria:

- they're accredited with the National Accreditation Authority for Translators and Interpreters (NAATI)
- they aren't a family member of the person
- they don't know or believe they may benefit from the death of the person
- they don't own, or are responsible for the day-to-day management of a health facility where the person lives or is being treated
- they aren't directly involved in providing health or professional care services to the person.

D Details of Final Request

The person must make a final request to access voluntary assisted dying.

The final request must be made:

- after the written declaration is signed and witnessed
- at least 9 calendar days after the date the patient made the first request, except if the coordinating and consulting medical practitioners have each independently assessed that patient's death is likely to occur before this
- at least 1 calendar day after the consulting assessment was completed.

The patient may make the final request by any means of communication available to them.

Date First Request made (DD/MM/YYYY): _____

Date Final Request made (DD/MM/YYYY): _____

It is my opinion, the patient is likely to die in less than 9 days after the first request was made; 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 can't be made until at least 9 calendar days after the date the patient made the first request.**

Signature

By signing and submitting this form you're stating you understand and agree to the below terms:

☐ I confirm the information I have provided is true and correct to the best of my knowledge.

☐ I confirm I have reviewed all the below forms in respect of the patient:

- the First Assessment Report form
- all Consulting Assessment Report forms
- the Written Declaration
- the Contact person appointment form.

☐ I confirm that the voluntary assisted dying request and assessment process for the patient has been completed in line with the *Voluntary Assisted Dying Act 2021*

☐ I am satisfied that the patient has decision making capacity in relation to voluntary assisted dying

☐ I am satisfied that the patient's request to access voluntary assisted dying is enduring.

☐ I have had regard to any decision made by the South Australian Civil and Administrative Tribunal (SACAT) in respect of a decision made in the voluntary assisted dying request and assessment process.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #:
Form reference #:
Episode reference #:
Practitioner VAD ID #:

SCHEDULE 6

Voluntary Assisted Dying

Practitioner administration permit application form

The coordinating medical practitioner must complete this form to apply for a voluntary assisted dying practitioner administration permit.

For more information about the permit application read the Voluntary assisted dying clinical guidelines at www.sahealth.sa.gov.au/vad.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Patient information

VAD Portal Patient ID: _____

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Coordinating practitioner information

Ahpra number: _____ VAD Portal Practitioner ID: _____

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Contact person information

Family name: _____

First name: _____

Other given name(s): _____

Date of Birth (DD/MM/YYYY): _____

Telephone number: _____

Email address: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

D Reason for practitioner administration permit

If the patient is physically capable of self-administration and able to digest enterally administered medicine at the time of final review you must apply for a self-administration permit.

The patient has been assessed as being physically incapable of digesting an enterally administered medication ☐ Yes ☐ No

The patient has been assessed as being physically incapable of self-administering the medication ☐ Yes ☐ No

E Permit details

Route of administration: ☐ Enteral ☐ Intravenous

Medication to be prescribed: _____

Signature of the Coordinating Practitioner

Practitioner's declaration

By signing this form, you are stating you understand and agree to all the below terms:

- I confirm that the patient is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence.
- I confirm that the patient has decision making capacity in relation to voluntary assisted dying.
- I confirm that the patient is acting voluntarily and without coercion.
- I confirm that the patient's request to access voluntary assisted dying is enduring.
- I confirm that the information I have provided is true and correct.
- I confirm that everyone named on this form knows their personal information is being disclosed as described.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #: Episode reference #:

Form reference #: Practitioner VAD ID #:

SCHEDULE 7

Voluntary Assisted Dying

Self-administration permit application form

The coordinating medical practitioner must complete this form to apply for a voluntary assisted dying self-administration permit.

For more information about the permit application read the Voluntary assisted dying clinical guidelines at www.sahealth.sa.gov.au/vad.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Patient information

VAD Portal Patient ID: _____

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Coordinating practitioner information

Ahpra number: _____ VAD Portal Practitioner ID: _____

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Contact person information

Family name: _____

First name: _____

Other given name(s): _____

Date of Birth (DD/MM/YYYY): _____

Telephone number: _____

Email address: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

D Permit details

Route of administration: _____

Medication to be prescribed: _____

Signature of the Coordinating Practitioner

Practitioner's declaration

By signing this form, you are stating you understand and agree to all the below terms:

- I confirm that the patient has decision making capacity in relation to voluntary assisted dying.
- I confirm that the patient is acting voluntarily and without coercion.
- I confirm that the patient's request to access voluntary assisted dying is enduring.
- I confirm that the information I have provided is true and correct.

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #: Episode reference #:

Form reference #: Practitioner VAD ID #:

SCHEDULE 8

Voluntary Assisted Dying

Self-administration permit

Granted under Division 2 of Part 5 of the Voluntary Assisted Dying Act 2021.

PERMIT NO:

Person/patient

Contact person

Coordinating Medical Practitioner

Issued by:

Date issued:

Voluntary Assisted Dying

Practitioner administration permit

Granted under Division 2 of Part 5 of the Voluntary Assisted Dying Act 2021.

PERMIT NO:

Person/patient

Contact person

Coordinating Medical Practitioner

Issued by:

Date issued:

SCHEDULE 9

Labeling Statement for the Voluntary Assisted Dying Substance

WARNING: IF INGESTED THIS MEDICINE WILL CAUSE DEATH

This medicine has been supplied in accordance with the *Voluntary Assisted Dying Act 2021* (SA), as authorised by the Voluntary Assisted Dying Permit issued by the Chief Executive of SA Health.

Only persons named on the Voluntary Assisted Dying permit are permitted to possess and/or administer this medication within South Australia.

This medication has been prescribed for the purposes of causing death.

Administration of this medication will result in death.

This medication must be stored in a locked box. The locked box must constructed of steel, must not be easily penetrable and must be of sturdy construction.

Any unused or remaining medication must be returned, by the person to whom it was dispensed or the relevant contact person, to a pharmacist at the SA Voluntary Assisted Dying Pharmacy Service.

SA Voluntary Assisted Dying Pharmacy Service
Repat Health Precinct Pharmacy
Daws Road, Daws Park SA 5041
7326 1746

SCHEDULE 10

Voluntary Assisted Dying

Substance dispensing form

Dispensing pharmacists must complete this form immediately after the voluntary assisted dying medication has been dispensed.

Submit completed forms in the Voluntary Assisted Dying Portal within 7 calendar days from the date the medication was dispensed.

SA Health uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Medicare number: _____ Medicare individual reference no: _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Pharmacist information

Dispensing Pharmacy: _____

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____

Email: _____

Work address (line 1): _____

Work address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Dispensing details

Details of medication dispensing (labelling requirements).

Permit number: _____

Date script requested (DD/MM/YYYY): _____

Date medication kit was issued within the dispensing software (DD/MM/YYYY): _____

Type of medication kit dispensed

- ☐ Enteral
- ☐ Intravenous

Details of the medication kit supply

Date medication kit was supplied (DD/MM/YYYY): _____

The medication was supplied to the:

- ☐ Patient
- ☐ Coordinating medical practitioner

Family name: _____

Given name: _____

Other given name(s): _____

Telephone number: _____

Email address: _____

Address (line 1): _____

Address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

AHPRA Registration Number
(for Registered Health Practitioners only): _____

D Certifying statements and signature of Pharmacist

By signing this form you are stating that you understand and agree to all the below terms:

☐ I confirm that the voluntary assisted dying medication was issued to the person as specified in the voluntary assisted dying permit

☐ I confirm that the voluntary assisted dying medication was labelled in accordance with the requirements of section 76 of the Act

☐ I confirm that the voluntary assisted medication was supplied to the person named on this form, in compliance with the voluntary assisted dying permit

☐ I confirm that information was supplied to the person to whom the medication kit was supplied in accordance with section 75 of the Act

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #:
Form reference #:
Episode reference #:
Pharmacist VAD ID #:

SCHEDULE 11

Voluntary Assisted Dying

Practitioner Administration Form

Completed by the Coordinating Practitioner.

The Coordinating Medical Practitioner uploads this form after administering the voluntary assisted dying substance to a patient as authorised by a practitioner administration permit.

The Coordinating Medical Practitioner must:

- Obtain a hard copy of the form prior to the time of administration
- Ensure an eligible witness completes Part C of the form at the time of administration
- Complete the form (except Part C) at the time of administration
- Upload the completed form within 7 business days after administration

Submitting this form constitutes giving a copy to Voluntary Assisted Dying Board.

For more information about practitioner administration refer to the VAD Prescribing and Administration Handbook.

The Department for Health and Wellbeing uses, stores and shares your personal information in line with the Voluntary assisted dying privacy statement.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Coordinating Practitioner information

Ahpra number: _____ VAD Portal Practitioner ID: _____

Family name: _____

First name: _____

Other given name(s): _____

Phone: _____

Email: _____

Practice address (line 1): _____

Practice address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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 Coordinating Practitioner; or
- are employed or engaged under a contract for services by the Coordinating Practitioner.

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

By signing this form, you as the witness are stating you understand and agree to all the below terms:

- ☐ I certify that the patient appeared to have decision making capacity in relation to voluntary assisted dying at the time of making the administration request.
- ☐ I certify that the patient appeared to be acting voluntarily and without coercion.
- ☐ I certify that the patient request to access voluntary assisted dying appeared to be enduring.
- ☐ I certify that the Coordinating Medical Practitioner administered the voluntary assisted dying substance to the patient in my presence.

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) _____

Location where administration occurred

- ☐ Public Hospital (ward other than Palliative Care Unit)
- ☐ Private Hospital (ward other than Palliative Care Unit)
- ☐ Hospice or Palliative Care Unit
- ☐ Residential aged care facility
- ☐ 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): _____

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

Did any complications occur following the administration of the prescribed substance?

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

Signature of Coordinating Practitioner

By signing this form, you are stating you understand and agree to all the below terms:

☐ I am eligible to act as an Administering Practitioner for this patient in accordance with section 27 of the ***Voluntary Assisted Dying Act 2021.***

I certify that the patient:

☐ was physically incapable of self-administering or digesting the voluntary assisted dying medication

☐ at the time of making the administration request, had decision making capacity in relation to voluntary assisted dying

☐ was acting voluntarily and without coercion

☐ was enduring in their request to access voluntary assisted dying

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

You must upload this completed form to the Clinical Portal within 7 days of administering a voluntary assisted dying substance under a practitioner administration permit.

Administrative use only

Patient reference #:
Form reference #:
Episode reference #:
Practitioner VAD ID #:

SCHEDULE 12

Voluntary Assisted Dying

Substance disposal form

A Pharmacist from the dispensing pharmacy completes this form after disposing of a dispensed voluntary assisted dying substance.

The Pharmacist must complete this form immediately after disposing of the substance.

Submitting this form constitutes giving a copy to Voluntary Assisted Dying Board.

A Patient information

Family name: _____

Given name: _____

Other given name(s): _____

Date of birth (DD/MM/YYYY): _____

Phone: _____ ☐ No phone

Email: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

B Pharmacist information

Family name: _____

Given name: _____

Other given name(s): _____

Phone: _____

Email: _____

Work address (line 1): _____

Work address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

C Details of Disposal

Reason for disposal

- ☐ Patient has requested change of administration route (This will revoke the permit)
- ☐ Patient has died before using the substance
- ☐ Patient opted out of the VAD Process (This will revoke the permit)
- ☐ Substance was damaged
- ☐ Substance has been administered
- ☐ Other

Date substance was given to Pharmacist (DD/MM/YYYY): _____

Date substance was disposed of by Pharmacist (DD/MM/YYYY): _____

Person who gave voluntary assisted dying substance to Pharmacist

Family name: _____

Given name: _____

Other given name(s): _____

Telephone number: _____

Email address: _____

Home address (line 1): _____

Home address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

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

Mailing address (line 1): _____

Mailing address (line 2): _____

Suburb: _____ State: _____ Postcode: _____

D Signature of Pharmacist

Signature: _____ Date (DD/MM/YYYY): _____

Name: _____

Administrative use only

Patient reference #:

Form reference #:

Episode reference #:

Pharmacist VAD ID #:

All instruments appearing in this gazette are to be considered official, and obeyed as such

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