Voluntary Assisted Dying in Tasmania

Form 1 - First Request Form

Voluntary assisted dying is a legal process that enables a person who is suffering from a medical condition to access a substance to end their life.

Under section 18 of the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (the Act), a person who wishes to access voluntary assisted dying, and who has received the relevant facts in relation to accessing voluntary assisted dying (the *Relevant Facts*) from a medical practitioner, can ask the medical practitioner to determine whether they are eligible to access voluntary assisted dying. This is the person's First Request.

A First Request can be made verbally, or in writing. A person who chooses to make a written request may use this form if they wish.

Fields marked with an asterisk (*) are compulsory. All other fields are optional.

Please complete the form using BLOCK LETTERS.

Part A: Patient Information

*	Given Name			
	Middle Name(s)			
*	Family Name			
*	Date of Birth (DD/MM/YYYY)			
*	Home Address			
*	Suburb			
*	State		* Postcode	
*	Daytime Phone Number			
	Email Address			
	Country of Birth			
	Language spoken at home			

How do you describe your gender? Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

☐ Man or Male ☐ Woman or Female ☐ Prefer not to answer

☐ Non-binary ☐ [I/they] use a different term (please specify) _____

Are you of Aboriginal or Torres Strait Islander origin? (If you are both Aboriginal and Torres Strait Islander origin, mark both the "Yes, Aboriginal" and "Yes, Torres Strait Islander" boxes)

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

What is your highest level of education?

☐ Did not complete high school ☐ Completed high school ☐ Completed tertiary education

Part B: Medical Practitioner Information

*	Given Name			
	Middle Name(s)			
*	Family Name			
	Date of Birth (DD/MM/YYYY)			
	Practice Name			
*	Practice Address			
*	Suburb			
*	State		* Postcode	
*	Daytime Phone Number			
	Email Address			
	Ahpra registration number			

Part C: Other Medical Practitioner Information

* Is the medical practitioner named in Part B of this form your usual medical practitioner?

☐ Yes ☐ No

If No is ticked, please complete the Usual Medical Practitioner Information below.

Usual Medical Practitioner Information (if applicable)

*	Given Name			
	Middle Name(s)			
*	Family Name			
	Practice Name			
*	Practice Address			
*	Suburb			
*	State		Postcode *	
*	Daytime Phone Number			
	Email Address			
	Ahpra registration number			

* Do you have a regular, non-GP specialist? ☐ Yes ☐ No

If Yes is ticked, please complete the Specialist Medical Practitioner Information below.

Specialist Medical Practitioner Information (if applicable)

*	Given Name			
	Middle Name(s)			
*	Family Name			
	Practice Name			
*	Practice Address			
*	Suburb			
*	State		Postcode *	
*	Daytime Phone Number			
	Email Address			
	Specialty			
	Ahpra registration number			

* Does anyone else have information that may be relevant to deciding whether you are eligible to access voluntary assisted dying? ☐ Yes ☐ No

If Yes is ticked, please complete the Additional Person Information below.

Additional Person Information (if applicable)

*	Given Name			
	Middle Name(s)			
*	Family Name			
*	Address			
*	Suburb			
*	State		Postcode *	
*	Daytime Phone Number			
	Email Address			
	Ahpra registration number			

Part D: Communication Assistance

* Is this Request being communicated with the assistance of another person? ☐ Yes ☐ No

If Yes is ticked, please complete the Communication Assistance Information below.

Communication Assistance Information (if applicable)

What type of communication assistance is required?

☐ Language assistance

☐ Other communication assistance – please specify: _____

NB: To provide a person seeking assistance to access voluntary assisted dying with communication assistance, the person providing the assistance must meet all of the communication criteria below, unless the Voluntary Assisted Dying Commission is satisfied that there are reasonable grounds why one or more of the communication criteria ought not to apply.

The communication criteria are that:

☐ the person is **not** a member of the patient's family,

☐ the person **does not know or believe** that they are likely to directly or indirectly benefit from, or receive a financial benefit, directly or indirectly, as a result of the patient's death,

☐ the person is **not** the patient's residential care provider,

☐ the person is **not** directly involved in providing health services or professional care services to the patient,

☐ if the person **is** a translator or interpreter – the person is accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) as a translator in the relevant language.

Details of the person providing the communication assistance (if applicable):

*	Given Name	
	Middle Name(s)	
*	Family Name	
*	Daytime Telephone Number	
	Email Address	
	Accreditation details	

Does the person providing the communication assistance meet the communication criteria?

☐ Yes

☐ No

If No, please provide details of how the person providing the communication assistance does not meet the communication criteria and the reasons for why one or more of the criteria ought not apply:

Part E: First Request

* I, being the patient named in Part A of this form:

- confirm that I wish to access voluntary assisted dying, and
- confirm that the Medical Practitioner named in Part B of this form has provided me with the *Relevant Facts* in person and not by way of audio-visual link, and
- hereby request the Medical Practitioner named in Part B of this form to determine whether I am eligible to access voluntary assisted dying.

Signature

Date (DD/MM/YYYY)

Time (HH:MM AM/PM)

If the patient is unable to complete and/or sign this form, they may designate another person (the designated person) to complete and/or sign on their behalf.

The designated person can complete and/or sign this form on the patient's behalf if:

- the patient is unable to complete and/or sign the form themselves, and
- the patient has designated the person to complete and/or sign the form, and
- the designated person is an adult, and
- the designated person is not the same person as the person who provided the patient with communication assistance.

Details of the designated person

* Given Name	
Middle Name(s)	
* Family Name	
* Daytime Telephone Number	
Email Address	

Signature of the designated person

Date (DD/MM/YYYY)

Part F: Consent to Provide Relevant Facts

* If the medical practitioner named in Part B of this form accepts your First Request and determines that you are eligible to access voluntary assisted dying, do you consent to the medical practitioner named in Part B of this form:

- providing a member of your family with the *Relevant Facts*, and
- taking all reasonable steps to explain to that person the plan for you to access voluntary assisted dying including the arrangements to be made in relation to your body if you intend to obtain a private self-administration certificate and to self-administer the voluntary assisted dying substance without your administering health practitioner present?

☐ Yes ☐ No

If Yes is ticked, please complete the Contact Details Information below.

Contact Details Information (if relevant)

*	Given Name			
	Middle Name(s)			
*	Family Name			
*	Address			
*	Suburb			
*	State		Postcode *	
*	Daytime Phone Number			
	Email Address			
	Relationship to you			

Part G: Consent to Provide Determination

* If the medical practitioner named in Part B of this form accepts your First Request and determines that you are eligible to access voluntary assisted dying, do you want that medical practitioner to provide your usual medical practitioner with a copy of the medical practitioner's determination and a statement of reasons for the determination?

☐ Yes ☐ No

Part H: Additional Information

Is there anything you would like to add? Yes ☐ No ☐

If Yes is ticked, please provide details: