Voluntary Assisted Dying

First Request Form 1 – Patient's First

Request Main Points:

- This Form is to be completed by a person who wants to make a formal First Request, in writing, to access voluntary assisted dying.
- To be valid, this Form must be filled and signed by the person who wants to access voluntary assisted dying or their designated person. The Form cannot be filled or signed by the person's doctor, or by a person who has provided the patient with communication assistance.
- Parts of the First Request Form marked with an asterisk (*) must be filled.
- For a First Request to be valid, the person making it must have been given a copy of the *Relevant Facts* document, in hard copy and in person, by the doctor to whom the request is made

Instructions for Patients:

- Ask your doctor if they are prepared to take your First Request.
- Fill and sign the Form. If you can't sign the Form, Part E is to be signed by your designated person.
- Give a copy of the filled and signed Form to your doctor.
- Read the **Fact Sheet: Making a First Request** if you are unsure or need more information.
- Email vad@health.tas.gov.au or call 1800 568 956 (Monday – Friday, 9.00 am – 5.00 pm) if you need help.

Part A: Patient Information

* First Name	
Middle Name	
* 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 of 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

Are you in receipt of palliative care?

☐ No ☐ Yes

Why do you want to access voluntary assisted dying?

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

* Is the patient filling and signing this Form? ☐ Yes ☐ No

If "Yes" is selected, complete Parts B, E and F.

If "No" is selected, complete Parts B, C, D, E and F.

Part B: Medical Practitioner Information

* Given Name			
Middle Name			
* Family Name			
Practice Name			
* Practice Address			
* Suburb			
* State		* Postcode	
* Daytime phone number			
Email address			

Part C: Designated Person Information

* Given Name	
Middle Name	
* Last Name	
* Date of Birth (DD/MM/YYYY)	
* Relationship to the patient	

Part D: Designated Person Confirmation

* I, being the designated person named in Part C of this Form, hereby confirm that the patient named in Part A of this Form has designated me to (tick appropriate box)

☐ Complete the Form on the patient's behalf, or

☐ Complete, and sign, the Form on the patient's behalf.

* Signature

* Date

If "Complete the Form on the patient's behalf" is selected, the designated person is to sign this Part (Part D) and the patient is to sign Part E.

If "Complete, and sign, the Form on the patient's behalf" is selected, the designated person is to sign both this Part (Part D) and Part E.

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 document 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

Part F: Additional Information (Optional)

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

If Yes is ticked, please provide details:

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