Patient Registration Form

VADANZ
Voluntary Assisted Dying Australia & New Zealand

VADANZ is dedicated to the protection of your privacy. Only with your permission, your doctor will submit this form to VADANZ. De-identified information will be entered into a secure database for research purposes. Identifiable information, such as your name and contact information will **only** be entered into our database if you consent to being contacted by us. Your willingness to be involved in our database or further research **will not** affect your clinical management or eligibility to access Voluntary Assisted Dying (VAD) in any way.

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Sex:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Country: ☐**Australia**

☐**New Zealand**

Phone no: _____

Email: _____

Consent

I consent to the transmission of this form to VADANZ, and the storage and use of my deidentified data for research purposes

☐ **Yes** ☐ **No**

I consent to being contacted by VADANZ to discuss / be invited to participate in research. I understand this will require the storage and potential sharing of my name and contact details:

☐ **Yes** ☐ **No**

From time to time, VADANZ is asked by journalists to be put in contact with patients applying for VAD. Would you be comfortable being contacted by VADANZ to ask you if you would be willing to share your story with interested journalists?

Feel free to say NO

☐ **Yes** ☐ **No**

VADANZ, PO Box 596 Berwick VIC 3806 admin@vadanz.com.au fax. 03 9957 8104

Background

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1. Country of Birth: _____
2. Do you identify as Indigenous? (Aboriginal, Torres Strait Islander, Māori)

   ☐ Yes ☐ No

3. Language spoken at home: _____
4. Where do you live?

   ☐ Home ☐ With family ☐ Nursing home / long term care

5. Relationship status:

   ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Defacto

   ☐ Other / prefer not to say

6. Highest level of education achieved:

   ☐ None ☐ Primary School ☐ Secondary School ☐ Certificate level

   ☐ Bachelors degree ☐ Graduate diploma ☐ Postgraduate studies

7. Reason/s for accessing VAD (select as many as you like):

   ☐ Losing autonomy (for control)
   ☐ Loss of dignity
   ☐ I feel like a burden
   ☐ Inadequate pain control
   ☐ Financial implications of treatment
   ☐ Other:
   ☐ Less able to engage in activities making life enjoyable
   ☐ Losing control of bodily functions
   ☐ My family/friends/carers think I am a burden
   ☐ Fear of symptoms to come

_____

_____

8. Are you known to a community palliative care service?

   ☐ **Yes** ☐ **No**

9. If no, have you been offered a referral to palliative care previously?

   ☐ **Yes** ☐ **No**

10. Again, if no, would you like to discuss the role of palliative care more today?

    ☐ **Yes** ☐ **No**

11. How long have you known the doctor you are seeing today for?

    Years: _____ Months: _____

    ☐ First time

12. How long has it taken for you to find a doctor willing to see you for VAD?

_____

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Support Person Nomination

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The primary person supporting me through my application for VAD is:

_____

For the nominated support person:

The effect of supporting someone through applying for, or undergoing an assisted death is unclear. The evidence available suggests that there doesn't appear to be a worsening of the grief experienced by carers of assisted dying patients, but this data is not conclusive.

Would you be willing to be contacted by VADANZ to be invited to participate in research assessing the effect of VAD on support persons?

☐ **Yes** ☐ **No**

If yes, please complete your contact details below:

First Name: _____ **Last Name:** _____

Phone no: _____

Email: _____

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