



For Provider/Health Care Organization Use:
 Medical Record #: _____
 Or Patient Name: _____

Patient’s Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient’s Choice of Pharmacy Form

Instructions: This form is to be completed by the **qualified patient** and his or her two witnesses. A qualified patient is a capable adult who is a resident of the state of Hawai`i and has satisfied the requirements of the Our Care Our Choice Act. Please complete and provide this form to the attending physician after completion of the counseling provider’s evaluation (e.g. mental capacity evaluation or assessment) and consulting physician examination.

Waiting Period: Not less than 48 hours shall elapse between the date of the attending physician’s receipt of this completed written request and taking of steps to make available a prescription. Additionally, not less than 20 days shall elapse between the date of the initial oral request with the Attending Physician and date of the prescription.

I, _____ (print full name), am an adult of sound mind. I am suffering from _____, which my attending physician has determined is a terminal disease and that has been medically confirmed by a consulting physician.

I have received counseling to determine that I am capable and not suffering from undertreatment or nontreatment of depression or other conditions which may interfere with my ability to make an informed decision.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, the possibility that I may choose not to obtain or not to use the medication, and the feasible alternatives or additional treatment options, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.



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I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I am fully aware that the prescribed medication will end my life and while I expect to die when I take the medication prescribed. I also understand that my death may not be immediate, and my attending physician has counseled me about this possibility.

I make this request voluntarily and without reservation and I accept full moral responsibility for my actions.

Patient's Full Name: (Print): _____

Patient's Signature: _____ Date: _____



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Declaration of Witnesses

We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress or to have been induced by fraud, or subjected to undue influence when signing the request; **and**
- (d) Is not a patient for whom either of us is the attending physician.

Witness #1: _____
(print full name)

Witness #1: _____ Date: _____
(signature)

Witness #2: _____
(print full name)

Witness #2: _____ Date: _____
(signature)

NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate, or be employed at a health care facility where the person is a patient or resident.

Written Consent:

I consent for the attending physician to contact the pharmacist of my choice, to inform the pharmacist of the prescription, and to allow the attending physician to transmit the written prescription personally, by mail, or electronically to the pharmacist.

Patient's Full Name (Print): _____

Patient's Signature: _____ Date: _____