DO NOT CALL 911
OR
RESUSCITATE PATIENT

Print
Save
Clear

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

FINAL ATTESTATION FORM (FORM 5 OF 6)

Instructions for the Patient: The Our Care, Our Choice Act (OCOCA) is a Hawaii law that permits eligible adults to access Medical Aid in Dying (MAID). This form is intended to inform the Attending Provider when the qualified patient has self-administered the prescribed medication. Please complete this form within 48 hours prior to self-administering the prescribed medication and make arrangements to provide a copy to the Attending Provider.

I, _____ am an adult of sound mind.

I am suffering from _____, which my Attending Provider has determined is a terminal disease and that has been medically confirmed by a Consulting Provider.

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 prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, and pain control.

I understand that I still may choose not to use the medication prescribed and by signing this form I am under no obligation to use the medication prescribed.

I understand that I have the right to rescind this request at any time. I am fully aware that the prescribed medication will end my life and I expect to die when I take the medication prescribed. I also understand that my death may not be immediate, and my Attending Provider has counseled me about this possibility.

CHECK ONE:

☐ I have informed my family / friend of my decision.
☐ I have not informed my family / friend of my decision.

I attest I am making this decision voluntarily and without reservation.

Patient's Full Name (Print): _____

Patient's Signature: _____ Date: _____