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

PATIENT'S WRITTEN REQUEST FOR MEDICATION AND DECLARATION OF WITNESSES FORM (FORM 4 OF 6)

Instructions: 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 to be completed by the **qualified patient** and two witnesses. A qualified patient is a capable adult who is a resident of the state of Hawaii and has satisfied the requirements of the Our Care Our Choice Act/ Medical Aid in Dying. Please complete and provide this form to the Attending Provider after completion of the Consulting and Counseling Providers' evaluations.

Waiting Period: Unless waiting period has been waived, not less than 48 hours shall elapse between the date of the Attending Provider's receipt of this completed written request and the taking of steps to make available a prescription.

A. PATIENT'S WRITTEN REQUEST

I, _____ (print full name), 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 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 Provider prescribe medication that I may self-administer to end my life.

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

I consent for the Attending Provider to inform the Pharmacist of the prescription and transmit the written prescription personally, by mail, or electronically to the Pharmacist.

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

Initial all below:

_____ 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, my death may take longer, and my Attending Provider has counseled me about this possibility.

Patient's Full Name (Print): _____

Patient's Signature: _____ Date: _____

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B. DECLARATION OF WITNESSES

We declare that the person signing this request:

- Is personally known to us or has provided proof of identity;
- Signed this request in our presence;
- 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
- Is not a patient for whom either of us is the Attending Provider.

Witness 1: _____
Print Full Name

Witness 1: _____ Date: _____
Signature

Witness 2: _____
Print Full Name

Witness 2: _____ Date: _____
Signature

NOTE:
Only one of the two witnesses may be a relative (by blood, marriage, or adoption) of the person signing this request or entitled to any portion of the person's estate upon death.

Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.