



**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: \_\_\_\_\_

