



Individual Name: \_\_\_\_\_ Consultant/Volunteer: \_\_\_\_\_

**This handout is a tool intended for personal use to help you keep track of important information related to the choice of medical aid in dying. It is neither a requirement of any medical aid-in-dying legislation, nor do you need to submit it to any person or medical professional.**

**It is important to review and update (if necessary) your advance directive and POLST prior to taking the medical aid-in-dying medication.**

**IMPORTANT: You may wish to contact your doctor if your health status changes or you are concerned about symptoms that may interfere with your ability to ingest aid-in-dying medications (i.e. uncontrolled nausea & vomiting; concerns about swallowing or ability to plunge feeding tube; digestive issues; changes in mental status).**

- Durable power of attorney for health care (name/relationship/phone):  
\_\_\_\_\_
- Hospice: \_\_\_\_\_
  - If not on hospice:
    - Physician designated to sign the death certificate: \_\_\_\_\_
    - Individual designated to contact mortuary: \_\_\_\_\_
- Prescribing physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Consulting physician: \_\_\_\_\_
- Mental capacity evaluation if physician request. **Mandatory in Hawaii:**  
\_\_\_\_\_
- Date of 1st verbal request: \_\_\_\_\_ Physician Name: \_\_\_\_\_
- Date of 2nd verbal request: \_\_\_\_\_ Physician Name: \_\_\_\_\_
- Date of mental capacity evaluation: \_\_\_\_\_ Evaluator's Name: \_\_\_\_\_
- Date written request submitted: \_\_\_\_\_
- Aid-in-dying medication protocol prescribed: \_\_\_\_\_

- Physician or pharmacist designated to review medication: \_\_\_\_\_
- Date aid-in-dying prescription sent to pharmacy: \_\_\_\_\_
- Date of planned ingestion: \_\_\_\_\_
- Who knows about your plan: \_\_\_\_\_
- Who will be present during ingestion: \_\_\_\_\_
- Who will be your medical support on day of ingestion (hospice or doctor): \_\_\_\_\_ Phone Number: \_\_\_\_\_
- Individual plan for day of ingestion: \_\_\_\_\_  
\_\_\_\_\_
- Plan for support person(s): \_\_\_\_\_  
\_\_\_\_\_
- Plan for unexpected event (such as prolonged dying process, vomiting, waking up, etc)
  - Date(s) discussed: \_\_\_\_\_
  - Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- **For California and Hawaii ONLY:**
  - Date Final Attestation form completed: \_\_\_\_\_
  - Who will deliver form to prescribing physician: \_\_\_\_\_
  
- Additional Notes:

*Compassion & Choices' End-of-Life Consultation program (EOLC) provides information on the full range of options at the end of life. EOLC, and representatives of EOLC, do not provide medical or legal advice. We simply inform individuals of the available options.*