DO NOT CALL 911 or RESUSCITATE PATIENT

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

Final Attestation Form

Instructions for the Patient: Please complete within 48 hours prior to self-administering the prescribed medication. Upon completion, please keep a copy with you and provide a copy to your witness, family member or caregiver to return to the Attending Physician.

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 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 understand that I am requesting that my attending provider 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.

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

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 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.

I make this request voluntarily and without reservation.

Patient's Full Name (Print): _____

Patient's Signature: _____ Date: _____