## **DO NOT CALL 911 or RESUSCITATE PATIENT**



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

## Final Attestation Form

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

OPPPD/OUR CARE OUR CHOICE ACT (Eff. 1/1/19)