## REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____,
am an adult of sound mind and a resident of the State of California.

I am suffering from _____,
which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

**INITIAL ONE:**

_____ I have informed one or more members of 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 withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

**Signed:**_____ **Dated:**_____

## DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) is personally known to us or has provided proof of identity;
(b) voluntarily signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

**Witness 1:**_____ **Date:**_____

**Witness 2:**_____ **Date:**_____

**NOTE:** Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care entity where the person is a patient or resident.

# ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

| A | PATIENT INFORMATION |
|---|---|
| PATIENT'S NAME (LAST, FIRST, M.I | DATE OF BIRTH |
| PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE) | |

| B | ATTENDING PHYSICIAN INFORMATION |
|---|---|
| PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER<br>( ) - |
| MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| PHYSICIAN'S LICENSE NUMBER | |

| C | CONSULTING PHYSICIAN INFORMATION |
|---|---|
| PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER<br>( ) - |
| MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| PHYSICIAN'S LICENSE NUMBER | |

| D | ELIGIBILITY DETERMINATION |
|---|---|
| 1. TERMINAL DISEASE | |
| 2. CHECK BOXES FOR COMPLIANCE: | |

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient is a resident of California.
- ☐ 3. Determination that patient has the capacity to make medical decisions**
- ☐ 4. Determination that patient is acting voluntarily.
- ☐ 5. Determination of capacity by mental health specialist, if necessary.
- ☐ 6. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with ingesting the requested aid-in-dying drug;
- ☐ d) The probable result of ingesting the aid-in-dying drug;
- ☐ e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it

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| E | **ADDITIONAL COMPLIANCE REQUIREMENTS** |
|---|---|

☐ 1. Counseled patient about the importance of all of the following:
☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
☐ b) Having another person present when he or she ingests the aid-in-dying drug;
☐ c) Not ingesting the aid-in-dying drug in a public place;
☐ d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
☐ e) Participating in a hospice program or palliative care program.
☐ 2. Informed patient of right to rescind request (1st time)
☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion
☐ 5. First oral request for aid-in-dying: __/__/__ Attending physician initials:____
☐ 6. Second oral request for aid-in-dying: __/__/__ Attending physician initials:____
☐ 7. Written request submitted: __/__/____ Attending physician initials:____
☐ 8. Offered patient right to rescind (2nd time)

| F | **PATIENT'S MENTAL STATUS** |
|---|---|

Check one of the following **(required):**

☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder.

Mental health specialist's information, if applicable:

| MENTAL HEALTH SPECIALIST NAME |
|---|
| MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER |
| MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE) |

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| G | **MEDICATION PRESCRIBED** |
|---|---|
| PHARMACIST NAME | TELEPHONE NUMBER<br>( ) - |

1. Aid-in-dying medication prescribed:
   - ☐ a. Name: _____
   - ☐ b. Dosage: _____

2. Antiemetic medication prescribed:
   - ☐ a. Name: _____
   - ☐ b. Dosage: _____

3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically

4. Date medication was prescribed: ____/ /_____

| X | PHYSICIAN'S SIGNATURE | DATE |
|---|---|---|
| | NAME (PLEASE PRINT) | |

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.