CONSENT
TO CONTACT PHARMACY REGARDING PRESCRIPTION FOR AID IN DYING DRUG

1. _____
   (Name of Patient)
2. I have a terminal disease and have requested a prescription for an aid in dying drug to self-administer in accordance with the End of Life Options Act (EOLOA).
3. I have been fully informed by my attending physician of all of the following:
   a. My medical diagnosis and prognosis;
   b. The potential risks associated with taking the drug to be prescribed;
   c. The probable result of taking the drug to be prescribed;
   d. That I may choose not to obtain the drug or may obtain the drug but may decide not to ingest it; and
   e. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

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4. I have had sufficient opportunity to discuss my condition and options with my physicians, and all of my questions have been answered to my satisfaction.
5. I consent to my attending physician or my attending physician's designee contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist..

Date: _____ _____
PATIENT NAME

Witness:_____

Interpreter's verification: I declare that I have read to the patient and/or if appropriate his/her representative the entire contents of this document in the language, which the patient had requested to be used.

Interpreter's Name:_____

Language Line Operator Name:_____ Language Line Operator Number:_____

Witness:_____Witness:_____