ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ILLINOIS END-OF-LIFE OPTIONS FOR TERMINALLY ILL PATIENTS ACT
REQUEST FOR MEDICATION TO END MY LIFE IN A PEACEFUL MANNER

I, _____ (NAME OF PATIENT), am an adult of sound mind, and a resident of Illinois. I have been diagnosed with _____ (NAME OF CONDITION) and given a terminal disease prognosis of 6 months or less to live by my attending physician.

I affirm that my terminal disease diagnosis was given or confirmed during at least one in-person visit to a health care professional.

I have been fully informed of the feasible alternatives and concurrent or additional treatment opportunities for my terminal disease, including, but not limited to, comfort care, palliative care, hospice care, or pain control, as well as the potential risks and benefits of each. I have been offered, have received, or have been offered and received resources or referrals to pursue these alternatives and concurrent or additional treatment opportunities for my terminal disease.

I have been fully informed of the nature of the medication to be prescribed, including the risks and benefits, and I understand that the likely outcome of self-administering the medication is death.

I understand that I can rescind this request at any time, that I am under no obligation to fill the prescription once written, and that I have no duty to self-administer the medication if I obtain it.

I request that my attending physician furnish a prescription for medication that will end my life if I choose to self-administer it, and I authorize my attending physician to transmit the prescription to a pharmacist to dispense the medication at a time of my choosing.

I make this request voluntarily, free from coercion or undue influence.

Patient Signature _____

Patient Printed Name _____ Date _____

Witness #1 Signature _____ Relationship _____

Witness #1 Printed Name _____ Date _____

Witness #2 Signature _____ Relationship _____

Witness #2 Printed Name _____ Date _____

All signatures must be inked (wet). No digital signatures are accepted.

Please include in the patient's medical record.

IDPH
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