Washington State Department of HEALTH

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Instructions for the Pharmacy Dispensing Record

The Washington Death with Dignity Act (chapter 70.245 RCW) allows a qualified patient with a terminal illness with six months or less to live to request medication that the patient may self-administer to end their life. If you have questions about these instructions, contact DeathwithDignity@doh.wa.gov.

Dispensing Health Care Provider Requirements

The Death with Dignity Act only provides immunity from civil and criminal liability and disciplinary action for good faith compliance. The dispensing health care provider must submit this completed form to the Department of Health **within 30 calendar days** of dispensing the prescribed medication.

Send the completed forms to the Department of Health.

- **Online through REDCap: https://redcap.link/DeathWithDignity.**
- By fax: 360-200-7408
- By mail: Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Department of Health will contact you if the forms are missing information. We keep all information strictly confidential and only release aggregate information on an annual basis.

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Pharmacy Dispensing Record

The dispensing health care provider must fill out and send the completed form to the Department of Health **within 30 calendar days** after dispensing the prescribed medication. Unless otherwise specified, fill out all text fields and check all boxes to indicate you completed the task.

A. Patient Information

Patient Name (Last, First, M.I.): _____ Date of Birth: _____

Mailing Address (Street, City, State, And Zip Code): _____

Phone Number: _____

B. Attending Qualified Medical Provider Confirmation

Name (Last, First, M.I.): _____ Title: _____

Mailing Address (Street, City, State, And Zip Code): _____

Phone Number: _____

C. Medications Dispensed

Prescription Date: _____ Dispense Date: _____

Check all medications dispensed and add the quantity for each medication.

- ☐ Diazepam Quantity _____
- ☐ Amitriptyline Quantity _____
- ☐ Digoxin Quantity _____
- ☐ Morphine Quantity _____
- ☐ Propranolol Quantity _____
- ☐ Phenobarbital Quantity _____
- ☐ Metoclopramide Quantity _____
- ☐ Haloperidol Quantity _____
- ☐ Odansetron Quantity _____
- ☐ Other (specify): _____ Quantity _____

Medications were: ☐ Picked-up ☐ Mailed

D. Dispensing Health Care Provider Confirmation

Provider Signature: _____ Date: _____

Name (Last, First, M.I.): _____ Title: _____

Mailing Address (Street, City, State, And Zip Code): _____

Email Address: _____ Phone Number: _____