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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: