For Provider/Health Care Organization Use:
Medical Record #: _____
Or Patient Name: _____

ATTENDING PHYSICIAN REPORTING FORM (MAIL-IN)

Instructions: The Our Care, Our Choice Act requires the Attending Physician to complete this reporting form within **30 calendar days** of the prescription date. Please attach all copies of supporting documentation as indicated at bottom and mail to the Hawai`i Department of Health, Office of Planning, Policy, and Program Development, Attn: OCOC/CONFIDENTIAL, 1250 Punchbowl St., Rm. 120, Honolulu, HI 96813. For inquiries on this form, you may contact the Department at (808) 586-4188. Please **do not fax or email** any patient information, completed forms and supporting documents to DOH.

Print Save Clear Form

A. PATIENT INFORMATION	
PATIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH
MEDICAL DIAGNOSIS AND PROGNOSIS	
PATIENT ENROLLED IN HOSPICE: ____ YES ____ NO (Please recommend patient to enroll in hospice if not enrolled.) Check here if recommended: _____	
B. ATTENDING PHYSICIAN INFORMATION	
ATTENDING PHYSICIAN NAME (LAST, FIRST, M.I.)	PHONE NUMBER
MAILING ADDRESS	
CITY, STATE AND ZIP CODE	
C. REQUESTS FOR MEDICATION	
1. FIRST ORAL REQUEST (Specify patient's request.)	DATE:
Recommended and Optional Actions (check all applicable boxes below): **I informed the patient and provided the following forms.** ___Patient's Written Request Form (includes Declaration of Witnesses and Written Consent)	

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	___ Final Attestation Form (optional) ___ Consulting Physician's Confirmation and Verification Form. For example, if the patient scheduled or has determined to meet with a consulting physician, acquire the consulting physician's name and phone number from the patient and make the referral. (optional) ___ Counselor's Statement of Determination Form. For example, if the patient scheduled or has determined to meet with a counselor (e.g. psychiatrist, psychologist, or licensed clinical social worker) for the purposes of expediting this process, acquire the counseling provider's name and phone number from the patient and make the referral. (optional) ___ I informed the patient that <u>not less than 20 days must pass</u> between the date of the first oral request and second oral request.	
	2. SECOND ORAL REQUEST (Specify patient's request.) **Must not be less than 20 days from the date of the first oral request.** <u>Initial below:</u> ___ I offered the patient the opportunity to rescind the request and informed the patient of his or her rights to rescind the request at any time. ___ (If applicable,) I provided the Final Attestation Form at the time of the patient's second oral request.	DATE:
	3. WRITTEN REQUEST (Physician notes if any; attach copy of the patient's completed written request)	DATE OF RECEIPT:
D. ACTIONS TAKEN TO COMPLY WITH LAW		
	Check all the following to indicate compliance: ___ 1. I determined that the patient has a terminal disease, is capable of medical decision-making and has made the request for the prescription voluntarily. ___ 2. I determined that the patient is a Hawai`i resident (e.g. Hawai`i driver's license, registration to vote, recent tax returns). ___ 3. I informed the patient of the following: ___ Patient's medical diagnosis;	

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___ Patient's prognosis;

___ Potential risks associated with taking the medication to be prescribed;

___ Probable result of taking the medication to be prescribed;

___ Possibility that the individual may choose not to obtain the medication or may obtain the medication but may decide not to use it; and

___ Feasible alternatives or additional treatment opportunities including but not limited to comfort care, hospice care, pain control.

___ 4. I recommended that the patient notify next of kin.

___ 5. I counseled the patient about the importance of having another person present when the qualified patient self-administers the medication and of not self-administering the prescription in a public place.

___ 6. I informed the patient of his or her right to rescind the request at any time and in any manner, and offered the patient (or qualified patient) an opportunity to rescind the request at the time of the patient's (or qualified patient's) second oral request made.

E. REFERRAL TO CONSULTING PHYSICIAN

I provided the Consulting Physician Confirmation and Verification Form to the following (check all applicable): ___ Patient ___ Consulting Physician **Note:** Attach Copy of Completed Consulting Physician's Confirmation and Verification Form	Date of Referral: Consulting Physician Name: Consulting Physician's Phone Number:

F. REFERRAL TO COUNSELING PROVIDER (e.g. Psychiatrist, Psychologist or Licensed Clinical Social Worker

I provided the Counseling Provider Confirmation and Verification Form to the following (check all applicable): ___ Patient ___ Counseling Provider **Note:** Attach Copy of Completed Counselor's State of Determination Form	Date of Referral: Counseling Provider Name: Counseling Provider Phone Number:

For Provider/Health Care Organization Use:
Medical Record #: _____
Or Patient Name: _____

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G. WRITING THE PRESCRIPTION

Waiting Period Requirements (initial below; both conditions must be met):

___ **Not less than 48 hours have passed between the DATE OF RECEIPT OF THE QUALIFIED PATIENT'S WRITTEN REQUEST and PRESCRIPTION DATE; and**

___ **Not less than 20 days have passed between the FIRST ORAL REQUEST and PRESCRIPTION DATE**

Name of Medication Prescribed (indicate here):

_____

Check all applicable below:

___ **Immediately prior to writing the prescription,** I verified that the patient is making an informed decision (required).

___ I dispensed medications directly; or

___ I contacted the pharmacist of the qualified patient's choice and informed the pharmacist of the prescription; and

___ I transmitted the written prescription personally, by mail or electronically to the pharmacist.

___ I provided the qualified patient the **Final Attestation Form** and advised qualified patient to complete the form 48 hours **prior to** self-ingesting the prescribed medication. Recommend that qualified patient keep a copy and designate an individual to return the original to the attending physician.

Date of Prescription:

H. ATTENDING PHYSICIAN'S STATEMENT

By signing below, I attest that I am a licensed physician pursuant to Hawai`i Revised Statutes Chapter 453 and that all requirements of the Our Care, Our Choice Act have been met and steps taken to carry out the request, including identification of the medication prescribed.

Attending Physician's Full Name (Print): _____

Attending Physician's Signature: _____

Date of Signature: _____

Required Attachments: 1) Patient's Written Request; 2) Consulting Physician's Confirmation and Verification Form; and 3) Counseling Provider's Statement of Determination Form.