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

ATTENDING PHYSICIAN FOLLOW-UP FORM (MAIL-IN)

Instructions: Within thirty (30) calendar days, following notification of the qualified patient's death from use of a prescribed medication, or any other cause, please complete this form and mail a copy to the Hawai`i Department of Health, Office of Planning, Policy and Program Development, ATTN: OCOCA/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 or related documents to DOH.

Print Save Clear Form

All information is kept strictly confidential.

1. **Patient's Full Name (Print)**: _____
2. **Date of Patient's Death**: _____
3. **Attending (Prescribing) Physician's Full Name (Print)**:

_____

4. **Attending Physician's Phone Number**: _____

1. Did the patient die from ingesting the medical aid-in-dying medication?

   Yes ☐ No ☐

   Unknown ☐

2. Patient's underlying illness: _____

_____

3. Was the patient enrolled in hospice at the time of death? Yes ☐ No ☐ Unknown ☐

4. What type(s) of health care insurance coverage did the patient have?
   Check all that apply:

   ☐ Medicare
   ☐ Private Insurance (e.g. Kaiser, HMSA, or other)
   ☐ Hawai`i Quest/Medicaid
   ☐ No Insurance
   ☐ Military/TRICARE
   ☐ Don't know type; had insurance.

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☐ V.A. ☐ Unknown

☐ Other: _____ (indicate other type of insurance)

5. Were there any complications or barriers? Please indicate below and/or provide comments.

☐ Yes ☐ No

6. If the patient died from self-administering an aid-in-dying medication, please provide the following information if known.

Education Level	**Race/Ethnicity**	**Sex**
☐ High School Diploma ☐ Some College, No Degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree	☐ White ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ African American ☐ Hispanic/Latino	☐ Male ☐ Female

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Statement by the Attending Physician: By signing below, I attest that I am a licensed physician pursuant to Hawai`i Revised Statutes Chapter 453 and acknowledge all requirements under the Our Care, Our Choice Act have been met.

Attending Physician's Full Name (Print): _____

Attending Physician's Signature: _____

Date: _____

PLEASE ATTACH A COPY OF THE FINAL ATTESTATION IF AVAILABLE.