



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

ATTENDING PROVIDER REPORTING FORM (FORM 1 OF 6)

Instructions: The Our Care, Our Choice Act (OCOCA) is a Hawaii law that permits eligible adults to access Medical Aid in Dying (MAID) & requires the Attending Provider to complete this reporting form within 30 calendar days of the prescription date. An Attending Provider (physician or APRN) is a Hawaii licensed provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s illness. Attach all copies of supporting documentation and mail to the Hawaii Department of Health (DOH), Office of Planning, Policy, and Program Development, Attn: OCOCA / CONFIDENTIAL, 1250 Punchbowl St., Rm. 120, Honolulu, HI 96813. Contact DOH with any questions at (808)586-4188. Do not fax/email any patient information (including completed forms/documents) to DOH.

A. PATIENT’S DEMOGRAPHIC INFORMATION

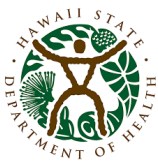
PATIENT’S NAME (LAST, FIRST, M.I.)		DATE OF BIRTH	
PATIENT’S ISLAND OF RESIDENCY		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
HEALTH INSURANCE COVERAGE (Check all that apply)	HIGHEST EDUCATION LEVEL (Choose one)	RACE/ETHNICITY (Check all that apply)	
<input type="checkbox"/> Hawai`i Quest/Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military/TRICARE <input type="checkbox"/> Private (e.g., Kaiser, HMSA) <input type="checkbox"/> Veterans Affairs Health Care <input type="checkbox"/> Don’t know type; had insurance <input type="checkbox"/> No insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> High school diploma / GED <input type="checkbox"/> Some college, no degree <input type="checkbox"/> Associate’s degree <input type="checkbox"/> Bachelor’s degree <input type="checkbox"/> Master’s degree <input type="checkbox"/> Doctoral degree <input type="checkbox"/> Professional degree <input type="checkbox"/> Unknown / Other	<input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	

B. PATIENT’S CLINICAL INFORMATION

MEDICAL DIAGNOSIS AND PROGNOSIS
PATIENT ENROLLED IN HOSPICE <input type="checkbox"/> YES <input type="checkbox"/> NO (If not enrolled, recommend patient to enroll in hospice) <input type="checkbox"/> Check here if recommended.

C. ATTENDING PROVIDER’S INFORMATION

ATTENDING PROVIDER NAME (LAST, FIRST, M.I.)	ORGANIZATION
PROVIDER TYPE <input type="checkbox"/> APRN <input type="checkbox"/> PHYSICIAN	ATTENDING PROVIDER ISLAND
MAILING ADDRESS	PHONE NUMBER
CITY, STATE AND ZIP CODE	EMAIL ADDRESS



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D. REQUESTS FOR MEDICATION

FIRST ORAL REQUEST (Specify patient's request)	DATE OF FIRST ORAL REQUEST
<p>I informed the patient of the requirements below:</p> <p><input type="checkbox"/> Patient's Written Request for Medication and Declaration of Witnesses Form</p> <p><input type="checkbox"/> Consulting Provider's Confirmation and Verification Form</p> <p><input type="checkbox"/> Counseling Provider's Statement of Determination Form</p> <p><input type="checkbox"/> Final Attestation Form</p> <p><input type="checkbox"/> Not less than 5 days must pass between the the first oral request and second oral request (unless waived)</p>	
<p>SECOND ORAL REQUEST (Specify patient's request)</p> <p>Initial below:</p> <p>_____ I informed the patient of their right to rescind the request at any time.</p> <p>_____ I provided the Final Attestation Form to at the time of the patient's second oral request.</p>	DATE OF SECOND ORAL REQUEST
PATIENT'S WRITTEN REQUEST	DATE OF RECEIPT

E. 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., Hawaii driver's license/civil identification card, Hawaii voter registration, most recent tax year filing, owns/leases property in Hawaii).
- 3. I informed the patient of the following:
 - a. Patient's medical diagnosis & prognosis;
 - b. Potential risks associated with taking the medication to be prescribed;
 - c. Probable result of taking the medication to be prescribed;
 - d. Possibility that the individual may choose not to obtain the medication or may obtain the medication but decide not to use it; and
 - e. Feasible alternative or additional treatment opportunities, including but not limited to comfort care, hospice care, and pain control;



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- 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 prescription and of not self-administering the prescription in a public place.
- 6. At the second oral request, I offered the patient an opportunity to rescind the request and informed the patient of their right to rescind the request at any time.

F. REFERRAL TO CONSULTING PROVIDER

Check provider type below: <input type="checkbox"/> Advanced Practice Registered Nurse (APRN) <input type="checkbox"/> Physician	DATE OF CONSULTING PROVIDER REFERRAL
	CONSULTING PROVIDER NAME
	CONSULTING PROVIDER PHONE NUMBER
	CONSULTING PROVIDER ISLAND

G. REFERRAL TO COUNSELING PROVIDER

Check provider type below: <input type="checkbox"/> Advanced Practice Registered Nurse (APRN) with a psychiatric or clinical nurse specialization <input type="checkbox"/> Licensed Clinical Social Worker (LCSW) <input type="checkbox"/> Licensed Marriage & Family Therapist (LMFT) <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist	DATE OF COUNSELING PROVIDER REFERRAL
	COUNSELING PROVIDER NAME
	COUNSELING PROVIDER PHONE NUMBER
	COUNSELING PROVIDER ISLAND



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H. WRITING THE PRESCRIPTION

Waiting Period Requirements

Initial below:

_____ **Not less than 5 days have passed** between the First Oral Request and Second Oral Request **AND** **Not less than 48 hours have passed** between the Date of Receipt of the Patient's Written Request and Date of Prescription

OR

_____ I am waiving all waiting periods.

Check all the following to indicate compliance:

- Immediately prior to writing the prescription, I verified that the patient is making an informed decision;**
- I contacted the pharmacist of the patient's choice and informed the pharmacist of the prescription;
- I transmitted the written prescription personally, by mail or electronically to the pharmacist;
- I provided the patient the **Final Attestation Form** and advised patient to complete the form 48 hours prior to self-ingesting the prescribed medication.

DATE OF WRITTEN PRESCRIPTION

NAME OF MEDICATION PRESCRIBED

- DDMA
- DDMAPh
- Other (please specify):

I. ATTENDING PROVIDER'S STATEMENT

By signing below, I attest that I am a licensed provider pursuant to Hawaii Revised Statutes Chapter 453 or Chapter 457 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 Provider's Full Name (Print): _____

Attending Provider's Signature: _____ Date: _____

Required Attachments (4):

- Attending Provider Reporting Form
- Patient's Written Request for Medication and Declaration of Witnesses Form
- Consulting Provider's Confirmation & Verification Form
- Counseling Provider's Statement of Determination Form