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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 ☐ Male ☐ Female ☐ _____

HEALTH INSURANCE COVERAGE (Check all that apply)	HIGHEST EDUCATION LEVEL (Choose one)	RACE/ETHNICITY (Check all that apply)
☐ Hawai`i Quest/Medicaid	☐ High school diploma / GED	☐ African
☐ Medicare	☐ Some college, no degree	☐ Asian
☐ Military/TRICARE	☐ Associate's degree	☐ Caucasian
☐ Private (e.g., Kaiser, HMSA)	☐ Bachelor's degree	☐ Hispanic/Latino
☐ Veterans Affairs Health Care	☐ Master's degree	☐ Native Hawaiian
☐ Don't know type; had insurance	☐ Doctoral degree	☐ Other Pacific Islander
☐ No insurance	☐ Professional degree	☐ Unknown
☐ Unknown	☐ Unknown / Other	☐ Other: _____
☐ Other: _____		_____

B. PATIENT'S CLINICAL INFORMATON

MEDICAL DIAGNOSIS AND PROGNOSIS

PATIENT ENROLLED IN HOSPICE
☐ YES ☐ NO (If not enrolled, recommend patient to enroll in hospice) ☐ Check here if recommended.

C. ATTENDING PROVIDER'S INFORMATION

ATTENDING PROVIDER NAME (LAST, FIRST, M.I.) PROVIDER TYPE ☐ APRN ☐ PHYSICIAN	ORGANIZATION 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

I informed the patient of the requirements below:

- ☐ Patient's Written Request for Medication and Declaration of Witnesses Form
- ☐ Consulting Provider's Confirmation and Verification Form
- ☐ Counseling Provider's Statement of Determination Form
- ☐ Final Attestation Form
- ☐ Not less than 5 days must pass between the the first oral request and second oral request (unless waived)

SECOND ORAL REQUEST (Specify patient's request) Initial below: _____ I informed the patient of their right to rescind the request at any time. _____ I provided the Final Attestation Form to at the time of the patient's second oral request.	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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ATTENDING PROVIDER REPORTING FORM (FORM 1 OF 6)

- ☐ 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:

- ☐ Advanced Practice Registered Nurse (APRN)
- ☐ 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:

- ☐ Advanced Practice Registered Nurse (APRN) with a psychiatric or clinical nurse specialization
- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Marriage & Family Therapist (LMFT)
- ☐ Psychiatrist
- ☐ Psychologist

DATE OF COUNSELING PROVIDER REFERRAL

COUNSELING PROVIDER NAME

COUNSELING PROVIDER PHONE NUMBER

COUNSELING PROVIDER ISLAND

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ATTENDING PROVIDER REPORTING FORM (FORM 1 OF 6)

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