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

ATTENDING PROVIDER'S FOLLOW-UP FORM (FORM 6 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). The 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 and is required to complete this form within thirty (30) calendar days, following notification of the qualified patient's death from use of a prescribed medication, or any other cause and mail a copy 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 INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	PATIENT'S DATE OF BIRTH
	PATIENT'S DATE OF DEATH ☐ Unknown

PATIENT'S UNDERLYING ILLNESS

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

☐ Yes ☐ No ☐ Unknown

If yes, did the patient have any complications or barriers? Please indicate below and/or provide comments.

☐ Yes ☐ No ☐ Unknown

Comments:

Was the patient enrolled in hospice at the time of death?

☐ Yes ☐ No ☐ Unknown

B. ATTENDING PROVIDER'S INFORMATION

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

C. ATTENDING PROVIDER'S STATEMENT

By signing below, I attest that I am a licensed provider pursuant to Hawai`i Revised Statutes Chapter 453 or Chapter 457 and acknowledge all requirements under the Our Care, Our Choice Act have been met.

Attending Provider's Full Name (Print): _____

Attending Provider's Signature: _____ Date: _____

Optional Attachment (1):

☐ Final Attestation Form