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

CONSULTING PROVIDER'S CONFIRMATION AND VERIFICATION FORM (FORM 2 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 Consulting Provider to complete this form and return to the Attending Provider. A Consulting 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.

A. PATIENT'S INFORMATION	
PATIENT'S NAME (LAST, FIRST, M.I.)	PATIENT'S DATE OF BIRTH
	DATE OF EXAMINATION
MEDICAL DIAGNOSIS	
PROGNOSIS	

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

CONSULTING PROVIDER'S CONFIRMATION AND VERIFICATION FORM (FORM 2 OF 6)

B. ATTENDING PROVIDER'S INFORMATION

ATTENDING PROVIDER'S NAME (LAST, FIRST, M.I.)

PROVIDER TYPE ☐ APRN ☐ PHYSICIAN

ATTENDING PROVIDER'S PHONE NUMBER

ATTENDING PROVIDER'S ADDRESS	ATTENDING PROVIDER'S ISLAND

C. CONSULTING PROVIDER'S INFORMATON

COUNSULTING PROVIDER'S NAME (LAST, FIRST, M.I.)

PROVIDER TYPE ☐ APRN ☐ PHYSICIAN

COUNSULTING PROVIDER'S PHONE NUMBER

COUNSULTING PROVIDER'S EMAIL ADDRESS

COUNSULTING PROVIDER'S ADDRESS	COUNSULTING PROVIDER'S ISLAND

D. CONFIRMATION AND VERIFICATION INFORMATION

I attest that I am a licensed provider pursuant to Hawai`i Revised Statutes Chapter 453 or Chapter 457 and I confirmed and verified all the following requirements. (Check all that apply)

☐ I examined the patient and patient's relevant medical records.
☐ The attending provider's diagnosis that the patient is suffering from a terminal illness.
☐ The attending provider's prognosis that the patient has 6 months or less to live.
☐ The patient is capable (i.e., has the capacity), acting voluntarily, and has made an informed decision.

Consulting Provider's Full Name (Print): ____

Consulting Provider's Signature: __________________________________ Date: ____________