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

COUNSELING PROVIDER'S STATEMENT OF DETERMINATION (FORM 3 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 Counseling Provider to complete this form and return to the Attending Provider. The Counseling Provider must be a Hawaii licensed Advanced Practice Registered Nurse (APRN) with a psychiatric or clinical nurse specialization, Psychiatrist, Psychologist, LCSW, or LMFT, who is qualified to determine that the patient has the mental capacity to make an informed health care decision, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision.
(Optional: The Counseling Provider may conduct the evaluation via telehealth.)

A. PATIENT'S INFORMATION

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

B. ATTENDING PROVIDER'S INFORMATION

ATTENDING PROVIDER'S NAME (LAST, FIRST, M.I.)	
ATTENDING PROVIDER'S PHONE NUMBER	
ATTENDING PROVIDER'S ADDRESS	ATTENDING PROVIDER'S ISLAND

C. COUNSELING PROVIDER'S INFORMATON

COUNSELING PROVIDER NAME (LAST, FIRST, M.I.)	
COUNSELING PROVIDER TYPE	
☐ Advanced Practice Registered Nurse (APRN) with psychiatric or clinical nurse specialization	☐ Licensed Marriage and Family Therapist (LMFT)
☐ Licensed Clinical Social Worker (LCSW)	☐ Psychiatrist
	☐ Psychologist
COUNSELING PROVIDER'S PHONE NUMBER	
COUNSELING PROVIDER'S EMAIL ADDRESS	
COUNSELING PROVIDER'S ADDRESS	COUNSELING PROVIDER'S ISLAND

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COUNSELING PROVIDER'S STATEMENT OF DETERMINATION (FORM 3 OF 6)

D. COUNSELING PROVIDER'S STATEMENT OF DETERMINATION

DATE OF EVALUATION

I have determined that the patient has the mental capacity and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision.

Check applicable statement below (required):

- ☐ I attest that I am a Licensed Marriage and Family Therapist (LMFT) under Hawaii Revised Statutes Chapter 451J.
- ☐ I attest that I am a licensed Psychiatrist under Hawaii Revised Statutes Chapter 453.
- ☐ I attest that I am an Advanced Practice Registered Nurse (APRN) with a psychiatric or clinical nurse specialization licensed under Hawaii Revised Statutes Chapter 457.
- ☐ I attest that I am a Licensed Psychologist under Hawaii Revised Statutes Chapter 465.
- ☐ I attest that I am a Licensed Clinical Social Worker (LCSW) under Hawaii Revised Statutes Chapter 467E.

Counseling Provider's Full Name (Print): _____

Counseling Provider's Signature: _____ Date: _____