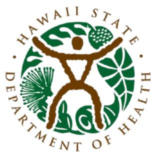

For Provider/Health Care Organization Use:
Medical Record #: ______________________
Or Patient Name: ______________________

ATTENDING PHYSICIAN FOLLOW-UP FORM (MAIL-IN)

Instructions: Within thirty (30) calendar days, following notification of the qualified patient's death from use of a prescribed medication, or any other cause, please complete this form and mail a copy to the Hawai`i Department of Health, Office of Planning, Policy and Program Development, ATTN: OCOC, 1250 Punchbowl St., Rm. 120, Honolulu HI 96813. For inquiries on this form, you may contact the Department at (808) 586-4188. Please **do not fax or email** any patient information, completed forms or related documents to DOH.

All information is kept strictly confidential.

1. **Patient's Full Name (Print)**: ____
2. **Date of Patient's Death**: ____
3. **Attending (Prescribing) Physician's Full Name (Print)**:

   ____
4. **Attending Physician's Phone Number**: _______________________________

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

   Yes ___ No ___

   Unknown ___

2. Patient's underlying illness: ____

   ____

3. Was the patient enrolled in hospice at the time of death? Yes ___ No ___ Unknown ___

4. What type(s) of health care insurance coverage did the patient have?
   Check all that apply:

   ___ Medicare

   ___ Private Insurance (e.g. Kaiser, HMSA, or other)

   ___ Hawai`i Quest/Medicaid

   ___ No Insurance

   ___ Military/TRICARE

   ___ Don't know type; had insurance.

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

ATTENDING PHYSICIAN FOLLOW-UP FORM (MAIL-IN)

___ V.A. ___ Unknown

___ Other: __________________________________ (indicate other type of insurance)

5. Were there any complications or barriers? Please indicate below and/or provide comments.

____ Yes _____ No

6. If the patient died from self-administering an aid-in-dying medication, please provide the following information if known.

Education Level	Race/Ethnicity	Sex
___ High School Diploma ___ Some College, No Degree ___ Associate's Degree ___ Bachelor's Degree ___ Master's Degree ___ Doctoral Degree	___ White ___ Asian ___ Native Hawaiian ___ Pacific Islander ___ African American ___ Hispanic/Latino	___ Male ___ Female

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Statement by the Attending Physician: By signing below, I attest that I am a licensed physician pursuant to Hawai`i Revised Statutes Chapter 453 and acknowledge all requirements under the Our Care, Our Choice Act have been met.

Attending Physician's Full Name (Print): ____________________________________

Attending Physician's Signature: ____

Date: ____________________________

PLEASE ATTACH A COPY OF THE FINAL ATTESTATION IF AVAILABLE.