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

CONSULTING PHYSICIAN
CONFIRMATION AND VERIFICATION FORM

Instructions: Please provide this form to the Consulting Physician to complete and return to the Attending Physician. A Consulting Physician is a Hawai`i licensed physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's illness. (Optional: The Consulting Physician may conduct the examination via telehealth.)

Print Save Clear Form

A. Patient Information

1. Full Name (Last, First, M.I.): _____
2. Date of Birth: _____
3. Date of Examination: _____
4. Medical Diagnosis:

5. Prognosis:

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

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B. Attending Physician's Information

1. Full Name (Last, First, M.I.): _____
2. Address: _____

_____

3. Phone Number: _____

C. Consulting Physician's Information

1. Full Name (Last, First, M.I.): _____
2. Address: _____

_____

3. Phone Number: _____
4. Email (if available): _____

D. Confirmation and Verification Information

I attest that I am a licensed physician pursuant to Hawai`i Revised Statutes Chapter 453 and confirmed and verified all of the following requirements. (Check box)

☐ I examined the patient and patient's relevant medical records.

☐ The attending physician's diagnosis that the patient is suffering from a terminal illness.

☐ The attending physician's prognosis that the patient has 6 months or less to live.

☐ The patient is capable (e.g. has the capacity), acting voluntarily, and has made an informed decision.

Consulting Physician's Full Name (Print): _____

Consulting Physician's Signature: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO THE ATTENDING PHYSICIAN