

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

COUNSELING PROVIDER'S STATEMENT OF DETERMINATION

<u>Instructions:</u> Please provide this form to the Counseling Provider to complete and return to the Attending Physician. The Counseling Provider must be a Hawai'i licensed psychiatrist, psychologist or licensed clinical social worker who is qualified to determine that the patient is capable (e.g. 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. (Optional: The counseling provider may conduct the evaluation via telehealth.)

A. Pa	A. Patient Information		
	1. Full Name (Last,	First, M.I.):	
	2. Date of Birth:		
B. At	ttending Physician's In	nformation	
	1. Full Name (Last,	First, M.I.):	
C. C	ounseling Provider's I	nformation	
	1. Full Name (Last,	First, M.I.):	
	2. Address:		
	4. Email (if available	le):	
	5. Profession (check	cone):	
	Psychiatrist	Psychologist	Licensed Clinical Social Worker



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D. Counseling Provider's Statement of Determination		
Date of the Evaluation:		
I have determined that the patient is capable (i.e. 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 psychiatrist under Hawai'i Revised Statutes Chapter 453		
I attest that I am a licensed psychologist under Hawai'i Revised Statutes Chapter 465		
I attest that I am a licensed clinical social worker under Hawai'i Revised Statutes Chapter 467E.		
Counseling Provider's Full Name (Print):		
Counseling Provider's Signature: Date:		

PLEASE RETURN COMPLETED FORM TO THE ATTENDING PHYSICIAN