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

# COUNSELING PROVIDER'S STATEMENT OF DETERMINATION

Instructions: 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.)

Print Save Clear Form

## A. Patient Information

1. Full Name (Last, First, M.I.): _____
2. Date of Birth: _____

## B. Attending Physician's Information

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

_____

3. Phone Number: _____

## C. Counseling Provider's Information

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

_____

3. Phone Number: _____
4. Email (if available): _____
5. Profession (check one):

☐ Psychiatrist ☐ Psychologist ☐ Licensed Clinical Social Worker

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

# COUNSELING PROVIDER'S STATEMENT OF DETERMINATION

**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**