



Medical Assistance in Dying
PATIENT REQUEST RECORD

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Patient Label

For cases involving a health authority (HA), when this Patient Request is first documented fax or mail a copy to applicable HA (pg 3). Retain original in patient's health record. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Form fields for Patient Information: Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate (YYYY / MM / DD), Gender (Male, Female, Other - specify), Patient's Home / Residence Address, Medical Diagnosis Relevant to Request for Assisted Death, Location at Time of Request (Home, Facility - Site, Unit, Other - specify).

PATIENT REQUEST

By initialing and signing below, I confirm that:

Confirmation statements for Patient Request, each with an 'Initials' field and a statement of consent or understanding regarding medical assistance in dying.

PATIENT SIGNATURE FOR INITIAL REQUEST (must be signed in front of the two independent witnesses listed on page 2)

Signature of Patient, Print Name, Date Signed

PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the patient and the two independent witnesses listed on page 2)

If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction. The proxy cannot be either of the witnesses listed on page 2 of this request form. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.

Signature of Proxy, Print Name, Relationship, Date Signed, Phone Number, Address, City, Province, Postal Code

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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**CONFIRMATION OF INDEPENDENT WITNESSES**

**By initialing and signing below, I confirm that:**

Witness 1	Witness 2	
Initials	Initials	I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
Initials	Initials	The patient is personally known to me or has provided proof of identity.
Initials	Initials	The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other witness.
Initials	Initials	I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or material benefit resulting from the patient's death.
Initials	Initials	I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides.
Initials	Initials	I am not directly involved in providing health care services to the patient.
Initials	Initials	I do not directly provide personal care to the patient.

**SIGNATURE OF INDEPENDENT WITNESSES (must be signed in the presence of the patient and the other witness)**

**WITNESS 1**

Signature of Witness 1	Print Name	Date Signed	Phone Number	
	Street Address and City		Province	Postal Code

**WITNESS 2**

Signature of Witness 2	Print Name	Date Signed	Phone Number	
	Street Address and City		Province	Postal Code

**NEAREST RELATIVE (OPTIONAL)**

Name of Nearest Relative	Relation	Contact Number
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Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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 **DO NOT COMPLETE** the section below until immediately prior to medical assistance in dying.

**PATIENT CONFIRMATION OF REQUEST AND CONSENT IMMEDIATELY PRIOR TO MEDICAL ASSISTANCE IN DYING**

**By signing below, I confirm that I was given the opportunity to withdraw my request, and I give express consent to receive medical assistance in dying at this time.**

Signature of Patient	Print Name	Date Signed
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**PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of patient)**

**If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction.** The proxy cannot be either of the witnesses listed on page 2 of this request form. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient.

Signature of Proxy	Print Name	Relationship
	Date Signed	Phone Number

Address	City	Province	Postal Code
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