

Shelter/Group Home

Other, Specify:

2023/01/04

Patient Label

Medical Assistance in Dying REQUEST FOR MEDICAL ASSISTANCE IN DYING ADDITIONAL INFORMATION ATTACHMENT

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If a written Request for MAiD was completed using the old (2-page) HLTH 1632 Request for MAiD form and assessments begin on or after January 1, 2023, the following questionnaire must be completed and attached to the existing HLTH 1632 Request for MAiD form. **REQUESTOR ADDITIONAL INFORMATION** Last Name First Name Second Name(s) Personal Health Number (PHN) Birthdate (YYYY / MM / DD) Sex at Birth □ N/A Male Female Intersex Preferred Gender Male Female X, Specify: I do not consent to provide information Do you identify as First Nations, Métis and/or Inuk/Inuit? If Yes (select all that apply): First Nations \bigcirc No Métis Inuk/Inuit O Do not know I do not consent to provide this information With which racial, ethnic or cultural group do you identify? (choose all that apply): South Asian (Indian, Pakistani, Bangladeshi, etc.) East Asian (Chinese, Korean, Japanese, Taiwanese) White (Caucasian) Latin American Another racial, ethnic or cultural group, **Specify:** _ Middle Eastern (Arab, Persian Lebanese, Turkish, etc.) Do not know South East Asian (Filipino, Thai, Vietnamese, etc.) I do not consent to provide this information In your opinion, do you If Yes, what type(s) of disability do you have? (select all that apply) have a disability? Developmental Other long term condition, **Specify:** _ Seeing Dexterity Hearing Pain-related Mental health related Do not know () Yes Mobility Learning Memory I do not consent to provide this information ○ No Flexibility O Do not know If Yes, how long have you had your disability? (If more than one disability, indicate the length of the longest disability) () I do not Months O Do not know I do not consent to provide this information consent to If Yes, how often does your disability limit daily activity? provide this information Never Rarely Sometimes Often Always O Do not know I do not consent to provide this information If you live in a private residence, who do you live with? Where is your usual place of residence? Private residence (including retirement home) – Live with family (partner, children, parents) O Hospital (excluding palliative care beds or unit) () Live alone Palliative care facility (including hospital-based palliative care beds, unit or hospice) Live with relatives Residential care facility (including long-term care facilities) Live with non-relatives Ocorrectional facility/Prison Other, Specify: _