BRITISH COLUMBIA | Ministry of Health

1632
2019/09/05

Medical Assistance in Dying

PATIENT REQUEST RECORD

Patient: submit this form to your doctor or nurse practitioner, or MAiD Care Coordination Service. Practitioner: if required, fax or mail a **COPY** of this form to the applicable health authority MAiD CCS. *See page 2 for MAiD Care Coordination Service contact information.*

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Birthdate (YYYY / MM / DD)	Gender ☐ Male ☐ Female ☐ Other (specify)

Patient's Home / Residence Address	Postal Code	Phone Number

Medical Diagnosis Relevant to Request for Medical Assistance in Dying

Location at Time of Request
☐ Home ☐ Facility/Other (specify):

Primary Health Care Provider (Name)	Phone Number

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name	First Name	ID Number	Date of Service (YYYY/MM/DD)

PATIENT REQUEST

By initialing and signing on the next page, I confirm that:

Initials	I am at least 18 years of age and I request medical assistance in dying. I make this request voluntarily and without pressure from others.
Initials	I have been fully informed of my diagnosis and prognosis and of options for treatments towards cure or control of my condition/disease, that may be applicable to my circumstances.
Initials	I believe that my medical condition is grievous and irremediable, my suffering is intolerable, there are no treatments that I consider acceptable, I am in an advanced state of irreversible decline, and my death is reasonably foreseeable.
Initials	Treatments for symptom control, including the potential benefits of palliative care or other treatment, have been described to me in a manner that I understand.
Initials	I consent to be assessed for eligibility and capability by a medical or nurse practitioner(s) and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient

By initialing and signing below, I confirm that:

Initials	I understand that my information will be shared with other health professionals involved in my care and as required by law.
Initials	I have had an opportunity to ask questions and request information, and I understand that I may continue to ask questions and seek additional information.
Initials	I expect to die when the medication to be prescribed is administered.
Initials	I understand that I have the right to change my mind at any time.

PATIENT SIGNATURE FOR INITIAL REQUEST (must be signed in front of 2 independent witnesses)

Signature of Patient	Print Name	Date Signed (YYYY / MM / DD)

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

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 to Patient
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Prov	Postal Code

Please go to Page 3 for Witness confirmations and signatures.

Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see:
https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms

Fraser Health Authority
Phone: 604-587-7878, Fax: 604-523-8855

Interior Health Authority
Phone: 1-844-469-7073, Fax: 250-469-7066

Northern Health Authority
Phone: 250-645-6417, Fax: 250-565-2640

Vancouver Coastal Health Authority
Phone: 1-844-550-5556, Fax: 1-888-865-2941

Vancouver Island Health Authority
Phone: 1-877-370-8699, Fax: 250-519-3669

Provincial Health Services Authority
Phone: 1-888-875-3256, Fax: 604-829-2631

This information is collected by the Ministry of Health under s.26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPP Act) and will be used for the purposes of monitoring and oversight for the provision of Medical Assistance in Dying in British Columbia. Should you have any questions about the collection of this personal information, please contact the Manager, Medical Assistance in Dying Oversight Unit at PO BOX 9638 STN PROV GOVT, Victoria BC V8W 9P1; 778-698-7497.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient

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 presence of patient and other witness)

WITNESS 1

Signature of Witness 1	Print Name	Relationship to Patient
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Prov	Postal Code

WITNESS 2

Signature of Witness 2	Print Name	Relationship to Patient
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Prov	Postal Code

PREFERRED CONTACT FOR PATIENT

Name of Preferred Contact	Relationship to Patient	Phone Number

The Patient Request Record is now complete. Submit this form to your physician or nurse practitioner, or you can contact your health authority's care coordination service for medical assistance in dying (contact information page 2).

PRINT CLEAR FORM