BRITISH COLUMBIA | Ministry of Health

1633
2023/01/11

Medical Assistance in Dying

ASSESSMENT RECORD (ASSESSOR)

Patient Label

Assessor is to provide this assessment to the Prescriber (if known) and health authority MAiD Care Coordination Service (MCCS) (if required). **If the assessment determines ineligibility, or if planning is discontinued, Assessor MUST fax all forms to the Ministry of Health at 778-698-4678** and MCCS (if required) **within 30 days.** Retain original in patient's health record.

1. PATIENT INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Birthdate (YYYY / MM / DD)	Sex at Birth ◯ Male ◯ Female ◯ Intersex

Preferred Gender
◯ Male ◯ Female ◯ X, **Specify:** ➤ ◯ Does not consent to provide information

Province or Territory that Issued PHN *If patient does not have a PHN, provide the province or territory of patient's usual place of residence*	Postal Code Associated With PHN *If patient does not have a PHN, provide postal code of patient's usual place of residence*

2. PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

◯ CPSID # ◯ BCCNM #	Phone Number	Fax Number	Work Email Address

Work Mailing Address	City	Postal Code

What is your specialty?
☐ Anaesthesiology ☐ Family Medicine ☐ Geriatric Medicine ☐ Neurology ☐ Palliative Medicine ☐ Other, **Specify:** ➤
☐ Cardiology ☐ General Internal Medicine ☐ Nephrology ☐ Oncology ☐ Respiratory Medicine

3. REQUEST FOR MAiD (Verbal or Written)

Initial Patient Request Date (YYYY / MM / DD)	From whom were you notified about the request for MAiD? ◯ Patient directly ◯ Another practitioner or preliminary assessor ◯ MAiD care coordination service ◯ Another third-party, **Specify:** ➤ _____

To the best of your knowledge or belief, before you were notified of the request for MAiD, did the patient consult you concerning their health for a reason other than seeking MAiD? ◯ Yes ◯ No	Province or Territory where you received the request for MAiD

Has the patient made a prior request for MAiD?
◯ Yes ◯ No ◯ Do Not Know

➤ **If Yes**, what was the outcome of that prior request for MAiD?
◯ Assessed and found ineligible
◯ Assessed and found eligible but person withdrew request
◯ Assessed and found eligible but considerable time elapsed since the assessment
◯ Request not actioned
◯ Other, **Specify:** ➤

4. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

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

THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.

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 9601 STN PROV GOVT, Victoria BC V8W 9P1; 236-478-1915.

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

5. ELIGIBILITY CRITERIA AND RELATED INFORMATION

Each assessing medical practitioner or nurse practitioner is to make these determinations of eligibility independently.

Assessment Date (YYYY / MM / DD)	◯ In Person ◯ By Telemedicine

Location of Patient at the Time of Assessment

◯ Home ◯ Facility - Site: ➤ Unit: ➤ ◯ Other, **Specify:** ➤

I confirm that ALL the following safeguards are met:

☐ The patient is personally known to me or has provided proof of identity, and has consented to this assessment; and,

☐ I do not know or believe that I am a beneficiary under the will of the patient requesting medical assistance in dying or a recipient, or in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for the services relating to the request.

I have determined that the patient has been fully informed of:

☐ Their medical diagnosis and prognosis; and,

☐ Their right to withdraw their request at any time and in any manner.

I have determined that the patient meets the following criteria to be eligible for medical assistance in dying:
(If any eligibility criterion is answered "No" or "Did Not Assess" the patient is NOT eligible for MAiD.)

◯ Yes ◯ No ◯ Did Not Assess	Is the patient eligible for health services funded by a government in Canada? *(Answer "Yes" if the patient would have been eligible but for an applicable minimum waiting period of residence or waiting period.)*
◯ Yes ◯ No ◯ Did Not Assess	Is the patient at least 18 years of age?
◯ Yes ◯ No ◯ Did Not Assess	Is the patient capable of making this health care decision?
◯ Yes ◯ No ◯ Did Not Assess	Did the patient make a voluntary request for MAiD that, in particular, was not made as a result of external pressure? **If Yes**, indicate why you are of this opinion (select all that apply): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAiD ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other, **Specify:** ➤
	If No, specify why in your opinion the request was not voluntary:
◯ Yes ◯ No ◯ Did Not Assess	Did the patient give informed consent to receive MAiD after having been informed of the means that were available to relieve their suffering, including palliative care? *Note: Palliative care is an approach that improves the quality of life of patients and their families facing life threatening illnesses, through the prevention and relief of pain and other physical symptoms, and psychological and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.*

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

Eligibility criteria for medical assistance in dying continued:

◯ Yes ◯ No ◯ Did Not Assess →

Does the patient have a serious and incurable illness, disease or disability*?

** For the purposes of MAiD eligibility, mental illness/disorder is not considered grievous and irremediable.*

If Yes, indicate the illness, disease or disability (select all that apply):

- ☐ Autoimmune condition
- ☐ Cancer – Breast
- ☐ Cancer – Colorectal
- ☐ Cancer – Hematologic
- ☐ Cancer – Lung
- ☐ Cancer – Ovary
- ☐ Cancer – Pancreas
- ☐ Cancer – Prostate
- ☐ Cancer – Other, **Specify below**
- ☐ Cardio-vascular condition – Atrial Fibrillation
- ☐ Cardio-vascular condition – Congestive Heart Failure
- ☐ Cardio-vascular condition – Vasculopathy
- ☐ Cardio-vascular condition – Other, **Specify below**
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Frailty (clinical score or severity, etc.), **Specify below**
- ☐ Mental Disorder* (excludes neurocognitive/ neurodevelopmental conditions), **Specify below**
- ☐ Neurological condition – Amyotrophic Lateral Sclerosis
- ☐ Neurological condition – Dementia
- ☐ Neurological condition – Multiple Sclerosis
- ☐ Neurological condition – Parkinson's Disease
- ☐ Neurological condition – Other, **Specify below**
- ☐ Organ failure – Kidney
- ☐ Organ failure – Liver
- ☐ Organ failure – Other, **Specify below**
- ☐ Respiratory Disease – Chronic Obstructive Pulmonary Disease
- ☐ Respiratory Disease – Pulmonary Fibrosis
- ☐ Respiratory Disease – Other, **Specify below**
- ☐ Other Condition/Co-Morbiditity, **Specify below**

Additional information relevant to patient's illness, disease, or disability

How long has the patient had the serious and incurable illness, disease or disability?

- ◯ Less than 3 months
- ◯ Between 3 months - less than 1 year
- ◯ Between 1 - less than 5 years
- ◯ Between 5 - less than 10 years
- ◯ Between 10 - less than 20 years
- ◯ 20 years or more
- ◯ Do not know

◯ Yes ◯ No ◯ Did Not Assess →

Is the patient in an advanced state of irreversible decline?

If Yes, what reasons led you to this opinion (select all that apply):

- ☐ Unable to do most or all activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs)
- ☐ Reduced or minimal oral intake or difficulty swallowing
- ☐ Dependent on life sustaining treatments
- ☐ Significant dependence on aid(s) for interaction/or mobility
- ☐ Severe shortness of breath
- ☐ Persistent extreme fatigue/weakness
- ☐ Cachexia
- ☐ Persistant, significant, and escalating chronic pain
- ☐ Other, **Specify:** ➤

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

Eligibility criteria for medical assistance in dying continued:

◯ Yes ◯ No ◯ Did Not Assess →

Does the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that is intolerable to them and can not be relieved under conditions that they consider acceptable?

If Yes, indicate how the patient described their suffering (select all that apply):

- ☐ Loss of ability to engage in activities making life meaningful
- ☐ Loss of dignity
- ☐ Isolation or loneliness
- ☐ Loss of ability to perform activities of daily living
- ☐ Loss of control of bodily functions
- ☐ Perceived burden on family, friends or caregivers
- ☐ Inadequate pain control, or concern about it
- ☐ Inadequate control of other symptoms, or concern about it
- ☐ Emotional distress/anxiety/fear/existential suffering
- ☐ Loss of independence
- ☐ Other, **Specify:** →

6. OTHER INFORMATION

◯ Yes ◯ No ◯ Do Not Know →

Does the patient require palliative care?

If Yes, did the patient receive palliative care?

◯ Yes ◯ No ◯ Do Not Know

→ **If Yes**, for how long?

- ◯ Less than 2 weeks
- ◯ 2 weeks to less than 1 month
- ◯ 1-6 months
- ◯ More than 6 months
- ◯ Do not know

→ **If Yes**, where was palliative care received? (Select all that apply)

- ☐ Home-based
- ☐ Hospital-based (in patient)
- ☐ Hospital-based (palliative care unit)
- ☐ Hospital-based outpatient or medical clinic / ambulatory service
- ☐ Long term care facility
- ☐ Hospice care
- ☐ Do not know

→ **If Yes**, what types of palliative care were received? (Select all that apply)

- ☐ Pain/symptom management
- ☐ Personal support services
- ☐ Volunteer supports
- ☐ Psychosocial care and/or counselling
- ☐ Spiritual care and/or counselling
- ☐ Palliative chemotherapy
- ☐ Palliative radiation therapy
- ☐ Physiotherapy
- ☐ Occupational therapy
- ☐ Do not know
- ☐ Other, **Specify:**

→ **If No**, was palliative care accessible to the patient?

◯ Yes ◯ No ◯ Do Not Know

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

Other Information – Disability Support

◯ Yes ◯ No ◯ Do Not Know

Does the patient require disability support services?

Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

If Yes, has the patient received disability support services?

◯ Yes ◯ No ◯ Do Not Know

If Yes, what disability support services were received? (Select all that apply)

- ☐ Aids to support physical mobility
- ☐ Aids to support audio/visual/communication
- ☐ Aid to support safety/access/transfers/ADLs
- ☐ Disability income supports
- ☐ Mental health / social support professional services
- ☐ Physical support services
- ☐ Physiotherapy
- ☐ Other, **Specify:**
- ☐ Do not know

If Yes, for how long?

- ☐ Less than 6 months
- ☐ 6 months to less than 1 year
- ☐ 1 year to less than 2 years
- ☐ 2 years or more
- ☐ Do not know

If No, were disability services accessible to the patient?

◯ Yes ◯ No ◯ Do Not Know

◯ Yes ◯ No

Did you consult with another health care professional in order to make a determination of eligibility? *(Do not include the other assessing practitioner or the practitioner providing expertise in the case of a Track 2 patient)*

If Yes, indicate the profession of those consulted (select all that apply):

- ☐ Nurse
- ☐ Primary care provider
- ☐ Palliative care specialist
- ☐ Social worker
- ☐ Oncologist
- ☐ Psychiatrist
- ☐ Other physician/Other consultation, **Specify:**

Consideration of capability to provide informed consent. Check one of the following:

(Capable means that person is able to understand the relevant information and the consequences of their choices)

◯ I have **no reason** to believe the patient is incapable of providing informed consent to medical assistance in dying.

OR

◯ I have **reason to be concerned** about the capability of the patient to provide informed consent.

☐ I have referred the patient to another practitioner for an assessment of capability to provide informed consent.

Name of Practitioner Performing Determination of Capability:

On receipt of the requested assessment, I determine that the patient:

◯ is capable of providing informed consent ◯ is **not** capable of providing informed consent

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

7. CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

☐ I have received and reviewed the completed copy of the patient's HLTH 1632 Request for MAiD Form
(This is now a requirement before a conclusion determining eligibility.)

Date Written Request Received (YYYY / MM / DD)

◯ Patient does meet **ALL** the criteria for medical assistance in dying and **natural death IS reasonably foreseeable** taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

OR

◯ Patient does meet **ALL** the criteria for medical assistance in dying and **natural death is NOT reasonably foreseeable** taking into account all of their medical circumstances. **GO TO SECTION 8.**

OR

◯ Patient does **NOT** meet **ALL** the criteria for medical assistance in dying. → *If the patient does not meet the eligibility criteria, the assessing practitioner should inform the Prescribing practitioner (if applicable) and inform the patient of their conclusion and that the patient may seek another assessment.*

Practitioner Signature	Date (YYYY / MM / DD)	Time

8. ADDITIONAL SAFEGUARDS – Patient's Natural Death NOT Reasonably Foreseeable (Non-RFND)

Start Date of Assessment (YYYY / MM / DD)	← Indicate the date on which your initial MAiD assessment began if earlier than the in person or telemedicine assessment date

☐ Either I or the Prescriber who determined eligibility (i.e. the prescriber) has expertise in the condition that causes the patient's suffering, or a third medical practitioner or nurse practitioner with expertise was consulted and the results have been shared with both assessors determining eligibility.

→ The practitioner with expertise in the condition causing the patient's suffering is:

◯ Assessor (self) ◯ Prescriber ◯ Third Practitioner - **Name** →

→ What was the expertise of the practitioner indicated above as it relates to the condition that is causing the patient's suffering? (Select all that apply)

- ☐ Cardiology
- ☐ General internal medicine
- ☐ Geriatric medicine
- ☐ Nephrology
- ☐ Neurology
- ☐ Oncology
- ☐ Psychiatry
- ☐ Pain management
- ☐ Respiratory medicine
- ☐ Other, **Specify:** →

Which means to relieve their suffering were discussed and offered to the patient?: (Select all that apply)

- ☐ Pharmacological
- ☐ Non-pharmacological (e.g. neuro stimulation, ECT)
- ☐ Counselling
- ☐ Mental health support
- ☐ Disability support
- ☐ Community services-income
- ☐ Community services-housing
- ☐ Community services-other
- ☐ Health care services including palliative care
- ☐ Other, **Specify**: →

Indicate how and on what basis you formed your opinion that the patieint has given serious consideration to the means to relieve their suffering? (Select all that apply)

- ☐ Consultation with patient
- ☐ Consultation with family/friends
- ☐ Consultation with professional care/medical providers
- ☐ Accepted/attempted multiple treatments appropriate for the condition
- ☐ Previous knowledge of patient
- ☐ Receptive to discussion on available means to relieve suffering
- ☐ Review of medical records
- ☐ Other, **Specify:** →

Date non-RFND MAiD safeguards were satisfied (YYYY / MM / DD)	**Practitioner Signature**

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

9. DISCONTINUATION OF PLANNING FOR MAiD

Indicate reason and fax this form along with the HLTH 1632 Request for MAiD to the Ministry of Health (778-698-4678) and appropriate Health Authority (if required):

◯ Patient withdrew request

If known, what were the person's reasons for withdrawing their request (Select all that apply):

- ☐ Means to relieve their suffering were accepted by the person
- ☐ The individuals the person wishes to respect do not support MAiD (religious leaders, family, caregivers, or professionals)
- ☐ Upon learning additional information about MAiD, the patient decided it was not the path they wish to pursue
- ☐ Meeting the needs of a transfer and/or consultation were too cumbersome for the patient
- ☐ Other, **Specify:**

If means to relieve their suffering were accepted and led the person to withdraw their request, which of these means were pursued (Select all that apply):

- ☐ Pharmacological
- ☐ Non-pharmacological (e.g. neuro stimulation, ECT)
- ☐ Counselling
- ☐ Mental health support
- ☐ Disability support services
- ☐ Community services- income
- ☐ Community services-housing
- ☐ Community services-other
- ☐ Health care services including palliative care
- ☐ Other, **Specify:**

Did the person withdraw their request after being given an opportunity to do so immediately before providing MAID?

◯ Yes ◯ No

◯ Patient no longer eligible

If the patient met all of the eligibility criteria but is no longer eligible, indicate which safeguard or eligibility criteria has not been met and specify the reason for this determination. (e.g. lost capacity to provide informed consent)

◯ Death occurred prior to administration

If known, what was the date of death? (YYYY / MM / DD)

◯ Do not know

Did you complete the medical certificate of death in the case where a person died of a cause other than MAID?

◯ Yes ◯ No

If yes, what was the immediate cause of death indicated on the death certificate?

If yes, what was the underlying cause of death indicated on the death certificate?

If known, what was the underlying reason(s) that led to the person dying of a natural death, before receiving MAID? (Select all that apply)

- ☐ Patient requested assessment but died before both assessments were completed by an MD/NP
- ☐ Approved person died before MAiD provision
- ☐ Referral time was too short
- ☐ Patient never chose a date to proceed or date chosen was too distant
- ☐ No assessor/provider available/willing
- ☐ Operational issues (i.e., could not be moved to a facility that allowed MAiD, medication shortages, bed shortages, health care personnel unavailable)
- ☐ Loss of capacity to consent without a waiver being completed
- ☐ Lack of pharmacy willing to provide MAiD medications
- ☐ Other, **Specify:**
- ☐ Do Not Know

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

Health Authority fax numbers for forms submission:

Fraser HA: Fax: 604-523-8855, mccc@fraserhealth.ca
Interior HA: Fax: 250-469-7066, maid@interiorhealth.ca
Northern HA: Fax: 250-565-2640, maid@northernhealth.ca
Vancouver Coastal HA: Fax: 1-888-865-2941, AssistedDying@vch.ca
Vancouver Island HA: Fax: 250-519-3669, maid@islandhealth.ca
Provincial Health Services Authority: Fax: 604-829-2631, maidcco@phsa.ca

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