BRITISH COLUMBIA | Ministry of Health

1634

Medical Assistance in Dying

ASSESSMENT RECORD (PRESCRIBER)

Patient Label

Prescriber is to fax this assessment to the health authority MAiD Care Coordination Service (if required). **If MAiD is administered, Prescriber must fax required all forms to the BC Ministry of Health at 778-698-4678 within 72 hours of confirmation of patient's death.** If assessment determines ineligibility, or if planning is discontinued, Prescriber must fax this form to the Ministry of Health within 30 days. Retain original in patient's health record.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

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

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 the postal code of patient's usual place of residence*

PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

☐ CPSID # ☐ BCCNP Prescriber #	Phone Number	Fax Number	Work Email Address

Work Mailing Address	City	Postal Code

If you are a physician, what is your specialty?

☐ Anaesthesiology ☐ Family Medicine ☐ Geriatric Medicine ☐ Neurology ☐ Palliative Medicine ☐ Other (specify)
☐ Cardiology ☐ General Internal Medicine ☐ Nephrology ☐ Oncology ☐ Respiratory Medicine

To the best of your knowledge or belief, before you received the written request for MAiD, did the patient consult you concerning their heath for a reason other than seeking MAiD? ☐ Yes ☐ No	Province or Territory where you received the written request for MAiD.

RECEIPT OF WRITTEN REQUEST FOR MAiD

From whom did you receive the written request?

☐ Patient directly (1632 form) ☐ Patient directly - other, specify:
☐ Another practitioner ☐ Another third-party - specify:
☐ Care coordination service

Date Written Request Received (YYYY / MM / DD)

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

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

ELIGIBILITY CRITERIA AND RELATED INFORMATION

Each assessing medical or nurse practitioner is to make these determinations independently, document in the health record, and summarize their findings below. *Comments for any matter in any section are clarified in the medical record.*

Assessment Date (YYYY / MM / DD)	☐ In Person ☐ By Telemedicine	If Telemedicine: Name of Witness (Regulated Health Professional)	Witness Profession	Witness College ID

Location of Assessment

☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:

I confirm that the following safeguards are met:

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

☐ 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, in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for their services relating to the request.

☐ I ensured that the patient's request for medical assistance in dying was made **in writing and signed and dated** by the patient or by another person permitted to do so on their behalf.

Indicate the date on which the patient (or other person) signed the request (YYYY / MM / DD): _____

☐ I was satisfied that the request was signed and dated by the patient, or by another person permitted to do so on their behalf, and before two independent witnesses who then signed and dated the request.

☐ I ensured that the request was signed and dated after the patient was informed by a practitioner that the patient had a grievous and irremediable medical condition.

☐ I was satisfied that the other practitioner and I are independent.

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

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

I confirm that the following safeguards are met: (cont.)

☐ I have ensured that another physician or nurse practitioner provided a second assessment (HLTH 1633) confirming that the patient met all of the criteria.

Was the practitioner a:

☐ Physician OR ☐ Nurse Practitioner

On what date did the other practitioner sign their second assessment? (yyyy/mm/dd) _____

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

☐ Their medical diagnosis and prognosis.

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

☐ The potential risks and probable outcome associated with taking the medication to be prescribed (i.e. patient expects to die when the medication is administered).

☐ The recommendation to seek advice on life insurance implications.

I have determined that the patient meets the following criteria to be eligible for medical assistance in dying:
If patient is ineligible based on one or more criteria, select "Did Not Assess" for any remaining criteria that are not assessed.

☐ 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:
☐ 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?
☐ Yes ☐ No ☐ Did Not Assess	Does the patient have a serious and incurable illness, disease or disability? If Yes, indicate the illness, disease or disability (select all that apply): ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other - specify below ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other (For stroke, select cardiovascular condition below) - specify below ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke) - specify below ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities - specify below ☐ Other illness, disease or disability - specify below
	Additional Information Relevant to Patient's Illness, Disease, or Disability

Medical Assistance in Dying ASSESSMENT RECORD (PRESCRIBER) Page 3 OF 6

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 — Is the patient in an advanced state of irreversible decline in capability?

☐ 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 (e.g., bathing, food preparation, finances)
- ☐ 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
- ☐ Other - Specify:

☐ Yes ☐ No ☐ Did Not Assess — Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?

Other Information

☐ Yes ☐ No — Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory written second assessment (HLTH 1633) required by the Criminal Code)?

If Yes, indicate what type of professional you consulted (select all that apply):

- ☐ Nurse
- ☐ Oncologist
- ☐ Palliative care specialist
- ☐ Primary care provider
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Social worker
- ☐ Speech pathologist
- ☐ Other health care professional – Specify:

☐ Yes ☐ No ☐ Do Not Know — Has the patient received palliative care?

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.

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 No, to the best of your knowledge or belief, was palliative care accessible to the patient?

☐ Yes ☐ No ☐ Do not know

☐ 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, 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, to the best of your knowledge or belief, were disability support services 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

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

Change in Eligibility (to be completed if, in your opinion, the patient was not eligible)

Had you previously determined that the patient was eligible for MAiD?

☐ Yes ☐ No

If Yes, was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health?

☐ Yes ☐ No

If Yes, did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)?

☐ Yes ☐ No

CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

I determine that the patient:

☐ Does meet the criteria for medical assistance in dying ☐ Does **not** meet the criteria for medical assistance in dying

If it is determined that the patient does not meet the criteria, the assessing practitioner is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.

Practitioner Signature	Date (YYYY / MM / DD)	Time

PLANNING FOR MEDICAL ASSISTANCE IN DYING

☐ I have received and reviewed the assessment by at least one other independent colleague (HLTH 1633) indicating the patient is eligible for medical assistance in dying.

☐ I have discussed with the patient the following options for administration and the patient has requested:

- ☐ Practitioner-administered Intravenous (IV) Regimen, or
- ☐ Patient self-administered Oral Regimen (supervised by practitioner)

☐ I have planned for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)

☐ There is a location and timeline for provision:

Planned Location: ☐ Home ☐ Facility - Site: _____ Unit: _____ ☐ Other - specify: _____

Planned Date: _____ Days From Initial Request (if fewer than 10 clear days) _____

☐ I ensured that there were at least **10 clear days** between the day on which the request was signed by or on behalf of the patient and the day on which MAiD was provided.

Where you considered a shorter period than 10 clear days appropriate in the circumstances, was it the patient's death or loss of capacity to provide informed consent that was deemed imminent?

- ☐ Patient's death
- ☐ Patient's loss of capacity to provide informed consent

☐ I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 72 hours after confirmation of death.

☐ I have indicated on the prescription or order that the medication is for medical assistance in dying.

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

If planning was discontinued prior to administration, indicate reason and submit this form to the Ministry of Health and appropriate Health Authority (if required):

☐ Patient withdrew request

If the patient withdrew request, what were their reasons (select all that apply):

- ☐ Palliative measures are sufficient
- ☐ Family members do not support MAiD
- ☐ Changed their mind
- ☐ Other - specify: _____
- ☐ Do not know

Did the patient withdraw their request after being given an opportunity to do so immediately before providing MAiD, as per Sec 241.2(3)(h) of the Criminal Code?

- ☐ Yes
- ☐ No

☐ Patient's capability deteriorated (no longer capable of providing informed consent)

☐ Death occurred prior to administration

Did you complete the medical certificate of death?

☐ Yes → What was the date of death? (YYYY / MM / DD): _____

What is the immediate cause of death on the medical certificate of death? _____

What is the underlying cause of death on the medical certificate of death? _____

☐ No → Provide the date of death (YYYY / MM / DD): _____

☐ Do not know

COMPLETE this section with patient 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	Date Signed (YYYY / MM / DD)

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 signing here can be one of the witnesses listed in the Patient Request Record. 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 to Patient
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Province	Postal Code

CONSENT VIA VERBAL OR OTHER MEANS (IF APPLICABLE)

If consent was provided via verbal or other means, and in the absence of a proxy, provide details on the steps taken to obtain consent.

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

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

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

ADMINISTRATION OF MEDICAL ASSISTANCE IN DYING

Date (YYYY / MM / DD)	Location Address

Location Type

- ☐ Hospital (exclude palliative care beds or unit)
- ☐ Palliative care facility (include hospital based palliative care beds/unit)
- ☐ Hospice
- ☐ Medical office or clinic
- ☐ Ambulatory setting
- ☐ Community care facility (include long term care)
- ☐ Assisted living residence
- ☐ Private residence (including patient's home)
- ☐ Other – specify: _____

If the patient had to be transferred to this location, was transfer due to an originating facility's policy regarding MAiD provision?

☐ Yes ☐ No ☐ Do Not Know

How was MAiD administered?

- ☐ IV
- ☐ Oral
- ☐ Oral and IV

Did the patient self-administer the substance?

- ☐ Yes → Were you present when the patient self-administered the substance? (In BC it is a requirement that the prescriber is present)
  - ☐ Yes ☐ No
- ☐ No

☐ Immediately before providing MAiD, I gave the patient an opportunity to withdraw their request and ensured that the patient gave express consent to receive MAiD.

☐ If the patient had difficulty communicating, I took all the necessary measures to provide a reliable means by which the patient could have understood the information that was provided to them and communicated their decision.

Supplementary Information – Provide supplementary information to clarify your responses, if applicable.

PRACTITIONER SIGNATURE

Practitioner Signature	Date (YYYY / MM / DD)	Time

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.

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855 **Northern HA:** Fax: 250-565-2640 **Vancouver Island HA:** Fax: 250-727-4335
Interior HA: Fax: 250-469-7066 **Vancouver Coastal HA:** Fax: 1-888-865-2941 **Provincial Health Services Authority:** Fax: 604-829-2631

PRINT CLEAR FORM