BRITISH COLUMBIA | Ministry of Health

1634
2023/01/11

Medical Assistance in Dying
ASSESSMENT RECORD (PRESCRIBER)

Patient Label

If MAiD is administered, Prescriber must fax all required forms to the BC Ministry of Health at 778-698-4678 and to the health authority MAiD Care Coordination Service (MCCS) (if required) **within 72 hours of con□rmation of patient's death.** If assessment determines ineligibility, or if planning is discontinued, Prescriber must fax all forms to the Ministry of Health 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)	Birthdate (YYYY / MM / DD)	Sex at Birth
☐ N/A		◯ Male ◯ Female ◯ Intersex

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

Province or Territory that Issued PHN	Postal Code Associated With PHN
If patient does not have a PHN, provide the province or territory of patient's usual place of residence	*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 noti□ed about the request for MAiD?
◯ Patient directly ◯ Another third-party, **Specify:** ➤
◯ Another practitioner or preliminary assessor
◯ MAiD care coordination service

To the best of your knowledge or belief, before you noti□ed about 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 eligibity 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 bene□ciary under the will of the patient requesting medical assistance in dying or a recipient, or in any other way, of a □nancial or other material bene□t resulting from the patient's death, other than the standard compensation for the services relating to the request; and,
- ☐ 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; and,
- ☐ I was satis□ed that the request was signed and dated by the patient, or by another person permitted to do so on their behalf, before one independent witness who then signed and dated the request.

Indicate the date the patient (or other person) signed the request:

➤ (**YYYY / MM / DD**):

Indicate the date the witness signed the request:

➤ (**YYYY / MM / DD**):

If the witness or proxy is a family member please indicate below the steps you took to satisfy yourself they were not a bene□ciary of the patient's death in any way.

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

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

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 su□ering, 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 su ering. 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-Morbidity, **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 di□culty swallowing
- ☐ Dependent on life sustaining treatments
- ☐ Signi□cant dependence on aid(s) for interaction/or mobility
- ☐ Severe shortness of breath
- ☐ Persistent extreme fatigue/weakness
- ☐ Cachexia
- ☐ Persistant, signi□cant, 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

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 persons)*

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:**

◯ 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

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

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

7. CONCLUSION OF ELIGIBILITY

☐ I have received and reviewed the completed copy of the patient's HLTH 1632 Request for MAiD Form

(This is now a requirement before concluding a determination of 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 speci□c 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. **(See Section 9 for additional safeguards.)**

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 must inform the patient of their conclusion and that the patient may seek another assessment.*

Practitioner Signature	Date (YYYY / MM / DD)	Time

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

8. DISCONTINUATION OF PLANNING FOR MAiD

Indicate reason and fax this form along with the HLTH 1632 Request for MAiD and HLTH 1633 (if completed) 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 medical certificate of death?

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

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
- ☐ Patient approved for MAiD but died before 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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Last Name of Patient	First Name of Patient	Second Name(s) of Patient

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

Date Assessment Period Began (YYYY / MM / DD)	Indicate the date on which the 90 clear days assessment period began (date first assessment by either the assessor or prescriber began).

☐ I have ensured that I or the other assessor who determined eligibility had expertise in the condition that causes the patient's suffering, or a third 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:

◯ Prescriber (Self) ◯ Assessor ◯ 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 ☐ Geriatric medicine ☐ Neurology ☐ Psychiatry ☐ Respiratory medicine
☐ General internal medicine ☐ Nephrology ☐ Oncology ☐ Pain management ☐ Other - **Specify:** →

☐ I ensured that the patient has been informed of reasonable and available means to relieve their suffering and that such consultations have been offered.

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

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

☐ I confirm the other assessing practitioner and I have discussed with the patient the reasonable and available means to relieve their suffering, and we agree that they have given these means serious consideration.

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

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

OR

◯ I ensured that there were at least **90 clear days** between the date of the first MAiD assessment (day 0) and the day on which MAiD was provided (**day 91 or later**).

◯ The second assessor and I agreed to shorten the 90 clear day period, as the patient was at imminent risk of losing capacity to provide consent to MAiD.

Date Non-RFND MAiD Safeguards were satisfied (YYYY / MM / DD)	**Practitioner Signature**

10. WAIVER OF FINAL CONSENT (ONLY applicable when patient's natural death IS reasonably foreseeable)

◯ Yes ◯ No The patient met all eligibility criteria and safeguards, and I have informed the patient of the risk of losing capacity to provide consent to receive medical assistance in dying.

◯ Yes ◯ No The patient and I have a written arrangement in place to waive final consent (HLTH 1645 Waiver of Final Consent) and the arrangement was made prior to the day the patient lost capacity to consent to receive medical assistance in dying, and before the Agreed Date of MAiD Provision on the arrangement.

11. PLANNING FOR MEDICAL ASSISTANCE IN DYING

If your patient has indicated interest in receiving information about organ donation on HLTH 1632 and meets inclusion criteria (age <80, No HIV, no metastatic cancer, willing to have provision in hospital) please call or send referral form to BC Transplant.

FORM: http://www.transplant.bc.ca/health-professionals/organ-donation-resources/organ-donation-after-maid

☐ 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: ◯ Medical Practitioner OR ◯ Nurse Practitioner

Date Other Practitioner Signed Second Assessment (YYYY/MM/DD)	Name of Other Medical Practitioner or Nurse Practitioner

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

☐ 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 prescribing medical practitioner or nurse practitioner)

Advanced consent is required to be completed with the patient immediately prior to patient self administering (Page 8)

☐ I have planned for potential challenges with administration (e.g. challenges with initiation of intravenous access, failure of oral route to achieve death, etc.)

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

☐ 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.

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

Complete section 12 or section 13 IMMEDIATELY prior to medical assistance in dying unless the patient lost capacity to consent and a waiver of final consent is in place.

12. PATIENT CONFIRMATION OF REQUEST AND CONSENT (INTRAVENOUS ADMINISTRATION)

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.

PATIENT SIGNATURE

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

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 Request for MAiD. **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.**

PROXY SIGNATURE (IF APPLICABLE) By signing below I confirm I signed in front of the Requestor and I meet ALL the above criteria to sign as the proxy.

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.

OR

13. SELF ADMINISTRATION (PATIENT ADVANCE CONSENT TO PRACTITIONER ADMINISTRATION of SECOND SUBSTANCE

This written arrangement is **REQUIRED by federal legislation 241.2 (3.5) between the medical practitioner or nurse practitioner (MAiD Prescriber) and patient** for the MAiD Prescriber to administer a second substance to cause the patient's death in the event that the substance self administered by the patient does not have the expected outcome and the patient loses capacity to provide consent.

PATIENT INFORMATION	MAiD PRESCRIBER INFORMATION (Medical Practitioner or Nurse Practitioner)
Patient Full Name	MAiD Prescriber Full Name

By initialing and signing below I confirm that I agree to the terms set out in this arrangement in the event the self administration of the substance to cause the patient's death does not have the expected outcome.

Patient Initials	MAiD Prescriber Initials	The MAiD Prescriber and patient agree to the following terms:
Initials	Initials	The MAiD Prescriber will be present at the time the patient self administers the MAiD substance that will cause their death.
Initials	Initials	If, after self-administering the first substance, the patient loses the capacity to provide consent to receive medical assistance in dying but does not die within a specified period, the patient consents to the MAiD Prescriber administering a second substance to cause their death.
Initials	Initials	The MAiD Prescriber will administer the second substance after _____ minutes

PATIENT SIGNATURE	DATE PATIENT SIGNED	MAiD PRESCRIBER SIGNATURE
Patient Signature	YYYY / MM / DD	MAiD Prescriber Signature

14. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED AT ADMINISTRATION

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

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

15. 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 o□ce or clinic
- ◯ Ambulatory setting
- ◯ Community care facility (include long term care)
- ◯ Assisted living residence
- ◯ Private residence (including patient's home)
- ◯ Other, **Specify:** ➤

Was the patient transferred to a di□erent facility for the provision of MAID?

◯ Yes ◯ No

➤ If YES, what were the reasons the person was transferred to another location? (choose all that apply):

- ☐ Public health recommendations
- ☐ Policies of the facility where the person was located
- ☐ Availability/capacity/comfort of practitioners within the facility where the person was located
- ☐ Privileges were not available in a timely manner (or at all) to the practitioners within the facility in which the person was located
- ☐ Person requested a transfer to an alternate location
- ☐ Other, **Specify:** ➤

If patient was transferred due to policies of a facility where the person was located, indicate name of facility

How was MAiD administered?

◯ IV - *complete section B or C below* ◯ Oral - *complete section A below* ◯ Oral and IV - *complete section A below*

A. PATIENT SELF ADMINISTERED ORAL MEDICATION AND PROVIDED SIGNATURE FOR ADVANCE CONSENT (If applicable)

Did the patient self-administer the substance?

◯ Yes ◯ No

☐ I was present while the patient self administered the the □rst substance to cause their death.

Did the patient die after self administering the □rst substance?

◯ Yes ◯ No → ☐ **If No,** I administered the second substance to cause the patient's death in accordance with the terms within the advance consent.

B. PATIENT HAD CAPACITY TO PROVIDE EXPRESS CONSENT (if applicable)

☐ 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.

Did the patient have di□culty communicating?

◯ Yes ◯ No

➤ If YES, Indicate the means/services that were used to communicate with the person to ensure the person was able to understand the information provided to them and communicate their decision (select all that apply):

- ☐ Independent translation/interpretive services
- ☐ Augmented and alternative communication devices/strategies (e.g. physical gestures, writing boards, eye gaze equipment, communication boards)
- ☐ Additional time
- ☐ Other, **Specify:** ➤

C. PATIENT PROVIDED DATE AND SIGNATURE FOR WAIVER OF FINAL CONSENT, THEN LOST CAPACITY (if applicable)

☐ The patient lost capacity to consent to receiving MAiD and the waiver of □nal consent waiver is included with the forms.

☐ I ensured the patient did not, by words, sounds or gestures, demonstrate refusal or resistance to having the substance administered.

☐ I ensured the substance was administered to the patient in accordance with the terms of the Waiver of Final Consent.

Supplementary Information – Provide supplementary information to clarify your responses, if applicable. *If more space is required please attach an additional page.*

16. PRACTITIONER SIGNATURE

Practitioner Signature	Date (YYYY / MM / DD)	Time

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