



Medical Assistance in Dying
CONSULTANT'S ASSESSMENT OF PATIENT'S
INFORMED CONSENT DECISION CAPABILITY

HLTH 1635

Consultant to fax this assessment to health authority MAiD Care Coordination Service, if required (see below). Retain original in patient's health record, and provide copy to referring practitioner who is responsible for reporting on MAiD to the Ministry of Health.

PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN) <input type="checkbox"/> N/A		Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:	

REFERRING PRACTITIONER

Last Name		First Name		CPSID #	OR	CRNBC Prescriber #	Phone Number
Mailing Address						City	Postal Code

CONSULTANT PRACTITIONER

Last Name		First Name and Initial		College #	Phone Number	Fax Number
Mailing Address			City	Postal Code	Email Address	
Specialty (if a family/general practitioner, indicate your additional training and expertise for an in-person capability assessment) <input type="checkbox"/> Psychiatry <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Other - specify:						

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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CONSULTANT PRACTITIONER ASSESSMENT AND DETERMINATION OF PATIENT'S CAPABILITY TO PROVIDE INFORMED CONSENT

Location of Assessment <input type="checkbox"/> Home <input type="checkbox"/> Facility/Other (specify):		Date(s) of Examinations(s)
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I confirm that on this/these dates, I met with the patient and informed them of the reason for this assessment, and I confirmed the patient's consent to conduct an assessment to determine their capability to consent to medical assistance in dying.

I have assessed the patient in person and have determined:

Initials	The patient does not have capability. A psychiatric illness/cognitive impairment is present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.
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OR

Initials	The patient has capability. A psychiatric illness/cognitive impairment is not present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.
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I have discussed my findings with the patient, and will advise the referring practitioner.

CONSULTANT PRACTITIONER SIGNATURE

Practitioner Signature		Date (YYYY / MM / DD)	Time
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THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855	Northern HA: Fax: 250-565-2640	Vancouver Island HA: Fax: 250-519-3669
Interior HA: Fax: 250-469-7066	Vancouver Coastal HA: Fax: 1-888-865-2941	Provincial Health Services Authority: Fax: 604-829-2631