

APPLICANT:

First name \_\_\_\_\_ Middle name \_\_\_\_\_  
Last name \_\_\_\_\_ Maiden name \_\_\_\_\_  
Care Card # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Postal Code \_\_\_\_\_

Is this a     House  
                   Apartment  
                   Nursing home  
                  Other \_\_\_\_\_

Telephone \_\_\_\_\_ email \_\_\_\_\_

Male

Female

Date of Birth (day/month/year) \_\_\_\_\_

Married     Widow(er)

Single     Common Law

Spouse/Partner \_\_\_\_\_

Child 1. \_\_\_\_\_

Child 2. \_\_\_\_\_

Child 3. \_\_\_\_\_

Child 4. \_\_\_\_\_

Health Providers:

Family Doctor \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Specialist (ie Cardiologist, Neurologist, Internist) \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Specialist \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Specialist \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Pharmacy\_\_\_\_\_

Address\_\_\_\_\_

Phone number\_\_\_\_\_

Pastoral Care/Spiritual Leader\_\_\_\_\_

Phone number\_\_\_\_\_

Are you being treated by any of the following:

Psychologist       Geriatrician       Psychiatrist   
Pain Specialist       Naturopath       Chiropractor

Do you experience any of the following? (check all that apply)

- Pain
- Psychological suffering
- Loss of independence
- Confusion
- Loss of sensation
- Loneliness/Isolation
- Hopelessness
- Nausea
- Fatigue
- Bedridden
- Other significant symptoms \_\_\_\_\_

What is your physical or mental health diagnosis?

\_\_\_\_\_

Are you being treated for this?     yes  no

Do you want to continue being treated for this?  yes  no

Do you want to start new treatments for this?     yes  no

Are you requesting Medical Aid in Dying (euthanasia or assisted death)?\_\_\_\_\_

If so, why?\_\_\_\_\_

\_\_\_\_\_

How long have you had this wish?\_\_\_\_\_

Have you spoken with your family doctor about this request?  yes  no

Have you spoken with any other doctor(s) about this?       yes  no

Are these doctors willing to help you with this request?       yes  no

Is your family aware of this request?       yes  no

Are you willing to have Dr. Green review your medical records?       yes  no  
(if yes you will be asked to sign a permission form)

Do you have a written euthanasia request?     yes  no  
Do you have a written Power of Attorney?     yes  no  
(if yes, who is named \_\_\_\_\_)

Do you have a treatment ban or Do Not Resuscitate order?                     yes  no  
Do you have an Advanced Directive?     yes  no

If yes to any of the above, please supply a copy of each document after the first consultation with Dr. Green and before, or with, the second consultation if proceeding.

This form has been completed by  self  other

If other:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

email \_\_\_\_\_

relation to applicant \_\_\_\_\_

Should we contact you or the applicant for further information? \_\_\_\_\_

#### Disclaimer

By signing this form you agree that this information will be included in your medical record. It will be handled by Dr.Green and her staff with the utmost respect and confidentiality as all medical records demand. This information may be used anonymously for data collection and review processes for scientific learning and teaching purposes and to evaluate the newly evolving field of Medical Aid in Dying in Canada.

Signature \_\_\_\_\_

Date \_\_\_\_\_

City \_\_\_\_\_