APPLICANT:

First name_____ Middle name_____
Last name_____ Maiden name_____
Care Card #_____

Address_____ City_____
Postal Code_____
Is this a O House
O Apartment
O Nursing home
Other_____
Telephone_____ email_____
Male O
FemaleO
Date of Birth (day/month/year)_____

Married O Widow(er) O
Single O Common Law O

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 O	Geriatrician O	Psychiatrist O
Pain Specialist O	Naturopath O	Chiropractor O

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

O Pain
O Psychological suffering
O Loss of independence
O Confusion
O Loss of sensation
O Loneliness/Isolation
O Hopelessness
O Nausea
O Fatigue
O Bedridden
O Other significant symptoms _____

What is your physical or mental health diagnosis?
_____

Are you being treated for this? O yes O no

Do you want to continue being treated for this? O yes O no
Do you want to start new treatments for this? O yes O 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? O yes O no
Have you spoken with any other doctor(s) about this? O yes O no
Are these doctors willing to help you with this request? O yes O no
Is your family aware of this request? O yes O no

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

Do you have a written euthanasia request? O yes O no
Do you have a written Power of Attorney? O yes O no
(if yes, who is named _____

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