



Solace

Medical Assistance in Dying

Dr. Stefanie Green

Tel: (250)592-4710

Fax: (250)592-4712

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 _____



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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 _____



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