BRITISH COLUMBIA | Ministry of Health

1637

Medical Assistance in Dying

PATIENT CONFIRMATION RECORD

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Patient Label

If MAiD is administered, prescriber to fax or mail a **COPY** of this form to applicable health authority (see below). Retain original in patient's health record. Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

COMPLETE this section in consultation with your medical practitioner or nurse practitioner.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

PATIENT CONFIRMATION OF CHOSEN METHOD (IV OR ORAL) OF MEDICAL ASSISTANCE IN DYING

Please initial option 1 or 2

1	Initials	Practitioner-administered **intravenous** medication (IV)

OR

2	Initials	Self-administered **oral** medication

By initialing below, I confirm that:

Initials — I understand that if I choose to take oral medication to end my life, and it does not work within the amount of time specified below (the amount of time agreed upon after discussion with my practitioner), my practitioner will administer IV medication to fulfill my request for medical assistance in dying.

amount of time _____

DO NOT COMPLETE this section until immediately prior to medical assistance in dying.

PATIENT CONFIRMATION OF REQUEST AND CONSENT IMMEDIATELY PRIOR TO MEDICAL ASSISTANCE IN DYING

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.

Signature of Patient	If consent was provided via verbal or other means, provide details on the steps taken to obtain consent
Date Signed (YYYY / MM / DD)	

PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of patient)

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 Patient Request Record. 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.

Signature of Proxy	Print Name	Relationship to Patient
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Province	Postal Code

PROFESSIONAL INTERPRETER (PLS OR OTHER) IF USED

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

Health Authority phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1636: http://www2.gov.bc.ca/assets/gov/health/forms/1636.pdf

Fraser Health Authority
Phone: 604-587-7878, Fax: 604-523-8855

Interior Health Authority
Phone: 1-877-442-2001, Fax: 250-469-7066

Northern Health Authority
Phone: 250-645-6417. Fax: 250-565-2640

Vancouver Coastal Health Authority
Phone: 1-844-550-5556. Fax: 1-888-865-2941

Vancouver Island Health Authority
Phone: 1-877-370-8699, Fax: 250-727-4335

Provincial Health Services Authority
Phone: 1-888-875-3256, Fax: 604-829-2631

PRINT

CLEAR FORM