



Medical Assistance in Dying ASSESSMENT RECORD (PRESCRIBER)

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Patient Label

Prescriber is to fax this assessment to the health authority MAiD Care Coordination Service (if required). If MAiD is administered, Prescriber must fax required all forms to the BC Ministry of Health at 778-698-4678 within 72 hours of confirmation of patient's death.

PATIENT INFORMATION

Form with fields: Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Gender, Province or Territory that Issued PHN, Postal Code Associated With PHN.

PRACTITIONER CONDUCTING ASSESSMENT

Form with fields: Last Name, First Name, Second Name, CPSID #, BCCNP Prescriber #, Phone Number, Fax Number, Work Email Address, Work Mailing Address, City, Postal Code.

Form with question: If you are a physician, what is your specialty? and checkboxes for various medical specialties.

Form with question: To the best of your knowledge or belief, before you received the written request for MAiD, did the patient consult you concerning their health for a reason other than seeking MAiD?

RECEIPT OF WRITTEN REQUEST FOR MAiD

Form with question: From whom did you receive the written request? and Date Written Request Received.

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Form with fields: Last Name, First Name, ID Number, Date of Service.

ELIGIBILITY CRITERIA AND RELATED INFORMATION

Each assessing medical or nurse practitioner is to make these determinations independently, document in the health record, and summarize their findings below.

Form with fields: Assessment Date, In Person/By Telemedicine, If Telemedicine: Name of Witness, Witness Profession, Witness College ID.

Form with question: Location of Assessment and checkboxes for Home, Facility - Site, Unit, Other - specify.

I confirm that the following safeguards are met:

Form with multiple checkboxes for confirming safeguards: patient identity, financial benefit, request signed and dated, independent witnesses, informed consent, independent practitioners.

THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
I confirm that the following safeguards are met: (cont.)		
<input type="checkbox"/> I have ensured that another physician or nurse practitioner provided a second assessment (HLTH 1633) confirming that the patient met all of the criteria. Was the practitioner a: <input type="checkbox"/> Physician OR <input type="checkbox"/> Nurse Practitioner On what date did the other practitioner sign their second assessment? (yyyy/mm/dd) _____		
I have determined that the patient has been fully informed of:		
<input type="checkbox"/> Their medical diagnosis and prognosis. <input type="checkbox"/> Their right to withdraw their request at any time and in any manner. <input type="checkbox"/> The potential risks and probable outcome associated with taking the medication to be prescribed (i.e. patient expects to die when the medication is administered). <input type="checkbox"/> The recommendation to seek advice on life insurance implications.		
I have determined that the patient meets the following criteria to be eligible for medical assistance in dying: <i>If patient is ineligible based on one or more criteria, select "Did Not Assess" for any remaining criteria that are not assessed.</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient eligible for health services funded by a government in Canada? (Answer "Yes" if the patient would have been eligible but for an applicable minimum waiting period of residence or waiting period.)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient at least 18 years of age?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient capable of making this health care decision?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Did the patient make a voluntary request for MAiD that, in particular, was not made as a result of external pressure? If Yes, indicate why you are of this opinion (select all that apply): <input type="checkbox"/> Consultation with patient <input type="checkbox"/> Knowledge of patient from prior consultations or treatment for reasons other than MAiD <input type="checkbox"/> Consultation with other health or social service professionals <input type="checkbox"/> Consultation with family members or friends <input type="checkbox"/> Reviewed medical records <input type="checkbox"/> Other - Specify:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Did the patient give informed consent to receive MAiD after having been informed of the means that were available to relieve their suffering, including palliative care?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Does the patient have a serious and incurable illness, disease or disability? If Yes, indicate the illness, disease or disability (select all that apply): <input type="checkbox"/> Cancer – lung and bronchus <input type="checkbox"/> Cancer – breast <input type="checkbox"/> Cancer – colorectal <input type="checkbox"/> Cancer – pancreas <input type="checkbox"/> Cancer – prostate <input type="checkbox"/> Cancer – ovary <input type="checkbox"/> Cancer – hematologic <input type="checkbox"/> Cancer – other - specify below <input type="checkbox"/> Neurological condition – multiple sclerosis <input type="checkbox"/> Neurological condition – amyotrophic lateral sclerosis <input type="checkbox"/> Neurological condition – other (For stroke, select cardiovascular condition below) - specify below <input type="checkbox"/> Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) <input type="checkbox"/> Cardio-vascular condition (e.g., congestive heart failure, stroke) - specify below <input type="checkbox"/> Other organ failure (e.g., end-stage renal disease) <input type="checkbox"/> Multiple co-morbidities - specify below <input type="checkbox"/> Other illness, disease or disability - specify below	
Additional Information Relevant to Patient's Illness, Disease, or Disability		

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
Eligibility criteria for medical assistance in dying continued:		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient in an advanced state of irreversible decline in capability?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Does the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that is intolerable to them and can not be relieved under conditions that they consider acceptable? If Yes , indicate how the patient described their suffering (select all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Loss of ability to engage in activities making life meaningful <input type="checkbox"/> Loss of dignity <input type="checkbox"/> Isolation or loneliness <input type="checkbox"/> Loss of ability to perform activities of daily living (e.g., bathing, food preparation, finances) <input type="checkbox"/> Loss of control of bodily functions <input type="checkbox"/> Perceived burden on family, friends or caregivers <input type="checkbox"/> Inadequate pain control, or concern about it <input type="checkbox"/> Inadequate control of other symptoms, or concern about it <input type="checkbox"/> Other - Specify: 	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?	
Other Information		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory written second assessment (HLTH 1633) required by the Criminal Code)? If Yes , indicate what type of professional you consulted (select all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Nurse <input type="checkbox"/> Oncologist <input type="checkbox"/> Palliative care specialist <input type="checkbox"/> Primary care provider <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Social worker <input type="checkbox"/> Speech pathologist <input type="checkbox"/> Other health care professional – Specify: 	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do Not Know	Has the patient received palliative care? <i>Palliative care is an approach that improves the quality of life of patients and their families facing life threatening illnesses, through the prevention and relief of pain and other physical symptoms, and psychological and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.</i> If Yes , for how long? <ul style="list-style-type: none"> <input type="checkbox"/> Less than 2 weeks <input type="checkbox"/> 2 weeks to less than 1 month <input type="checkbox"/> 1-6 months <input type="checkbox"/> More than 6 months <input type="checkbox"/> Do not know If No , to the best of your knowledge or belief, was palliative care accessible to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do Not Know	Does the patient require disability support services? <i>Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.</i> If Yes , has the patient received disability support services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do Not Know If Yes , for how long? <ul style="list-style-type: none"> <input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 months to less than 1 year <input type="checkbox"/> 1 year to less than 2 years <input type="checkbox"/> 2 years or more <input type="checkbox"/> Do not know If No , to the best of your knowledge or belief, were disability support services accessible to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do Not Know	

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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Consideration of capability to provide informed consent. Check one of the following:
(Capable means that person is able to understand the relevant information and the consequences of their choices)

I have **no reason** to believe the patient is incapable of providing informed consent to medical assistance in dying.

OR

I have **reason to be concerned** about the capability of the patient to provide informed consent.

I have referred the patient to another practitioner for an assessment of capability to provide informed consent.

Name of Practitioner Performing Determination of Capability

On receipt of the requested assessment, I determine that the patient:

is capable of providing informed consent

is **not** capable of providing informed consent

Change in Eligibility (to be completed if, in your opinion, the patient was not eligible)

Had you previously determined that the patient was eligible for MAiD?

Yes No

If Yes, was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health?

Yes No

If Yes, did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)?

Yes No

CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

I determine that the patient:

Does meet the criteria for medical assistance in dying

Does **not** meet the criteria for medical assistance in dying

If it is determined that the patient does not meet the criteria, the assessing practitioner is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.

Practitioner Signature	Date (YYYY / MM / DD)	Time
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PLANNING FOR MEDICAL ASSISTANCE IN DYING

I have received and reviewed the assessment by at least one other independent colleague (HLTH 1633) indicating the patient is eligible for medical assistance in dying.

I have discussed with the patient the following options for administration and the patient has requested:

Practitioner-administered Intravenous (IV) Regimen, or

Patient self-administered Oral Regimen (supervised by practitioner)

I have planned for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)

There is a location and timeline for provision:

Planned Location: Home Facility - Site: _____ Unit: _____ Other - specify: _____

Planned Date: _____ Days From Initial Request (if fewer than 10 clear days) _____

I ensured that there were at least **10 clear days** between the day on which the request was signed by or on behalf of the patient and the day on which MAiD was provided.

Where you considered a shorter period than 10 clear days appropriate in the circumstances, was it the patient's death or loss of capacity to provide informed consent that was deemed imminent?

Patient's death

Patient's loss of capacity to provide informed consent

I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 72 hours after confirmation of death.

I have indicated on the prescription or order that the medication is for medical assistance in dying.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
If planning was discontinued prior to administration, indicate reason and submit this form to the Ministry of Health and appropriate Health Authority (if required):		
<input type="checkbox"/> Patient withdrew request If the patient withdrew request, what were their reasons (select all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Palliative measures are sufficient <input type="checkbox"/> Family members do not support MAiD <input type="checkbox"/> Changed their mind <input type="checkbox"/> Other - specify: _____ <input type="checkbox"/> Do not know Did the patient withdraw their request after being given an opportunity to do so immediately before providing MAiD, as per Sec 241.2(3)(h) of the Criminal Code? <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No 		
<input type="checkbox"/> Patient's capability deteriorated (no longer capable of providing informed consent)		
<input type="checkbox"/> Death occurred prior to administration Did you complete the medical certificate of death? <ul style="list-style-type: none"> <input type="checkbox"/> Yes → What was the date of death? (YYYY / MM / DD): _____ What is the immediate cause of death on the medical certificate of death? _____ What is the underlying cause of death on the medical certificate of death? _____ <input type="checkbox"/> No → Provide the date of death (YYYY / MM / DD): _____ <input type="checkbox"/> Do not know 		

COMPLETE this section with patient 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	Date Signed (YYYY / MM / DD)
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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

CONSENT VIA VERBAL OR OTHER MEANS (IF APPLICABLE)

If consent was provided via verbal or other means, and in the absence of a proxy, provide details on the steps taken to obtain consent.

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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