BRITISH COLUMBIA | Ministry of Health

1645
2021/03/18

Medical Assistance in Dying

WAIVER OF FINAL CONSENT

Patient Label

If the Requestor loses capacity and MAiD is administered in accordance to the terms of this agreement, Prescriber must fax this and all required forms to the BC Ministry of Health at 778-698-4678 and to the health authority MAiD Care Coordination Service (if required) **within 72 hours** of confirmation of requestor's death. Retain original in requestor's health records.

Written arrangement between the Requestor named below and the MAiD Provider named below for medical assistance in dying in accordance with section 241.2(3.2) of the *Criminal Code of Canada* *(The waiver of final consent is ONLY applicable for individuals whose natural death is reasonably foreseeable)*

1. REQUESTOR INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Birthdate (YYYY / MM / DD)	Gender ◯ Male ◯ X (specify) ◯ Female

2. MAiD PROVIDER INFORMATION

Name of MAiD Provider	Phone Number	Agreed Date of MAiD Provision (YYYY/DD/DD)

3. REQUESTOR CONSENT

Initials	I, the Requestor named above, request that the MAiD Prescriber named above provide me with medical assistance in dying on the Agreed Date of MAiD Provision stated above.
Initials	I have been informed by the MAiD Prescriber named above that I meet the eligibility criteria set out in section 241.2(1) of the *Criminal Code of Canada* and that all other safeguards set out in subsection (3) have been met.
Initials	I have been informed by the MAiD Prescriber named above of the risk of losing capacity to consent to receiving medical assistance in dying prior to the day specified in this arrangement.
Initials	I consent to receive medical assistance in dying on the date above, even if I no longer have the capacity to consent to receive medical assistance in dying on that date.
Initials	I consent to the administration of a substance to cause my death by the MAiD Prescriber on or before the day specified in this arrangement if I lose capacity to consent to receive medical assistance in dying prior to that day.
Initials	I acknowledge that this agreement does not create any obligation for the MAiD Prescriber named above to administer me with MAiD. The MAiD Prescriber may decide not to administer MAiD under all circumstance.

4. MEDICAL PRACTITIONER OR NURSE PRACTITIONER

Initials	The Requestor named above has requested that I, the MAiD Prescriber named above, provide them with medical assistance in dying on Agreed Date of MAiD Provision.
Initials	The requestor named above has completed a *Request for Medical Assistance in Dying* as required in British Columbia.
Initials	The requestor named above meets the eligibility criteria set out in 241.2(1) of the *Criminal Code of Canada* and all other safeguards set out in subsection (3) have been met - requestor's death is reasonably foreseeable.
Initials	I have informed the requestor named above that they are at risk of losing capacity to consent to receiving medical assistance in dying prior to the day specified in this arrangement.
Initials	The requestor named above has given consent to receive medical assistance in dying on the date specified in this arrangement, even if they no longer have the capacity to consent on that date.
Initials	The requestor named above has given consent to the administration by me of a substance to cause their death on or before the day specified in this arrangement if they lose capacity to consent to receiving medical assistance in dying prior to that day.
Initials	I have agreed to provide medical assistance in dying to the requestor named above on the date specified in this agreement.
Initials	I have agreed to provide medical assistance in dying to the requestor named above on or before the date specified in this arrangement, if the requestor named above loses their capacity to consent to receive medical assistance in dying.

5. REQUESTOR SIGNATURE	DATE REQUESTOR SIGNED	6. MAiD PROVIDER SIGNATURE

Medical Assistance in Dying WAIVER OF FINAL CONSENT Page 2 OF 2

Last Name of Requestor	First Name of Requestor	Second Name(s) of Requestor

7. ADDITIONAL TERMS (Optional)

The Requestor and the MAiD Prescriber may agree to additional terms of this arrangement (for example, specific conditions or circumstances under which medical assistance in dying could be provided on a earlier date). NOTE: Both the Requestor and the MAiD Prescriber must be in agreement and MAiD must be provided in accordance with the terms of this arrangement.

Requestor's Initials	MAiD Prescriber's Initials	Additional Terms:
Initials	Initials	
Initials	Initials	
Initials	Initials	
Initials	Initials	
Initials	Initials	

8. REQUESTOR SIGNATURE (if applicable)	DATE REQUESTOR SIGNED	9. MAiD PROVIDER SIGNATURE (if applicable)

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855, mccc@fraserhealth.ca
Interior HA: Fax: 250-469-7066, maid@interiorhealth.ca
Northern HA: Fax: 250-565-2640, maid@northernhealth.ca
Vancouver Coastal HA: Fax: 1-888-865-2941, AssistedDying@vch.ca
Vancouver Island HA: Fax: 250-519-3669, maid@viha.ca
Provincial Health Services Authority: Fax: 604-829-2631, maidcco@psha.ca

This information is collected by the Ministry of Health under s.26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPP Act) and will be used for the purposes of monitoring and oversight for the provision of Medical Assistance in Dying in British Columbia. Should you have any questions about the collection of this personal information, please contact the Manager, Medical Assistance in Dying Oversight Unit at PO BOX 9638 STN PROV GOVT, Victoria BC V8W 9P1; 236-478-1915