BRITISH COLUMBIA | Ministry of Health

1633
2022/02/25

Medical Assistance in Dying

ASSESSMENT RECORD (ASSESSOR)

Patient Label

Assessor is to provide this assessment to the Prescriber (if known) and health authority MAiD Care Coordination Service (MCCS) (if required). **If the assessment determines ineligibility, or if planning is discontinued, Assessor MUST fax all forms to the Ministry of Health at 778-698-4678** and MCCS (if required) **within 30 days.** Retain original in patient's health record.

1. PATIENT INFORMATION

Last Name	First Name	Second Name(s)

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

Province or Territory that Issued PHN *If patient does not have a PHN, provide the province or territory of patient's usual place of residence*	Postal Code Associated With PHN *If patient does not have a PHN, provide the postal code of patient's usual place of residence*

2. PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

◯ CPSID # ◯ BCCNM #	Phone Number	Fax Number	Work Email Address

Work Mailing Address	City	Postal Code

What is your specialty?

☐ Anaesthesiology ☐ Family Medicine ☐ Geriatric Medicine ☐ Neurology ☐ Palliative Medicine ☐ Other (specify)
☐ Cardiology ☐ General Internal Medicine ☐ Nephrology ☐ Oncology ☐ Respiratory Medicine

3. RECEIPT OF WRITTEN REQUEST FOR MAiD

I received the patient's written request for MAiD

◯ Yes ◯ No

If Yes, complete all of Section 3

Date Written Request Received (YYYY / MM / DD)

From whom did you receive the written request for MAiD?

◯ Patient directly (1632 form) ◯ Patient directly - other, specify: ◯ Another third-party - specify:
◯ Another practitioner
◯ MAiD Care coordination service

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?

◯ Yes ◯ No

Province or Territory where you received the written request for MAiD

4. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

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

5. ELIGIBILITY CRITERIA AND RELATED INFORMATION

Each assessing medical practitioner or nurse practitioner is to make these determinations independently, document in the health record, and summarize their findings below. *Comments for any matter in any section are clarified in the medical record.*

Assessment Date (YYYY / MM / DD)

◯ In Person
◯ By Telemedicine

Location of Patient at the Time of Assessment

◯ Home ◯ Facility - Site: Unit: ◯ Other - specify:

I confirm that the following safeguards are met:

☐ The patient is personally known to me or has provided proof of identity, and has consented to this assessment.

☐ I do not know or believe that I am a beneficiary under the will of the patient requesting medical assistance in dying or a recipient, or in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for their services relating to the request.

I have determined that the patient has been fully informed of:

☐ Their medical diagnosis and prognosis.

☐ Their right to withdraw their request at any time and in any manner.

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

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.

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

I have determined that the patient meets the following criteria to be eligible for medical assistance in dying:
If patient is ineligible based on one or more criteria, select "Did Not Assess" for any remaining criteria that are not assessed.

◯ Yes ◯ No ◯ 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.)*
◯ Yes ◯ No ◯ Did Not Assess	Is the patient at least 18 years of age?
◯ Yes ◯ No ◯ Did Not Assess	Is the patient capable of making this health care decision?
◯ Yes ◯ No ◯ 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): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAiD ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other - Specify:
◯ Yes ◯ No ◯ 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? *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.*
◯ Yes ◯ No ◯ Did Not Assess →	Does the patient have a serious and incurable illness, disease or disability*? ** For the purpose of MAiD mental illness is not considered an illness, disease, or disability.* **If Yes**, indicate the illness, disease or disability (select all that apply): ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other - **specify below** ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other (For stroke, select cardiovascular condition below) - **specify below** ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke) - **specify below** ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities - **specify below** ☐ Other illness, disease or disability (e.g. Frailty with a clinical score or level of severity, etc.) - **specify below**
	Additional Information Relevant to Patient's Illness, Disease, or Disability

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

Eligibility criteria for medical assistance in dying continued:

◯ Yes ◯ No ◯ Did Not Assess — Is the patient in an advanced state of irreversible decline?

◯ Yes ◯ No ◯ 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):

- ☐ Loss of ability to engage in activities making life meaningful
- ☐ Loss of dignity
- ☐ Isolation or loneliness
- ☐ Loss of ability to perform activities of daily living (e.g., bathing, food preparation, finances)
- ☐ Loss of control of bodily functions
- ☐ Perceived burden on family, friends or caregivers
- ☐ Inadequate pain control, or concern about it
- ☐ Inadequate control of other symptoms, or concern about it
- ☐ Other - **Specify:**

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

6. CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

◯ Patient does meet **ALL** the criteria for medical assistance in dying and **natural death IS reasonably foreseeable** taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining.

OR

◯ Patient does meet **ALL** the criteria for medical assistance in dying and **natural death is NOT reasonably foreseeable** taking into account all of their medical circumstances.

→ ☐ Either I or the Prescriber who determined eligibility (i.e. the prescriber) has expertise in the condition that causes the patient's suffering, or a practitioner or nurse practitioner with expertise was consulted and the results have been shared with both assessors determining eligibility.

→ The practitioner with expertise in the condition causing the patient's suffering is:

◯ Assessor (self) ◯ Prescriber ◯ Other → If Other, Name of Practitioner: _____

→ _____ Indicate the date on which your initial MAiD assessment began if earlier than the in person or telemedicine assessment date.

YYYY / MM / DD

OR

◯ Patient does **NOT** meet **ALL** the criteria for medical assistance in dying. → *If the patient does not meet the eligibility criteria, the assessing practitioner should inform the Prescribing practitioner (if applicable) and inform the patient of their conclusion and that the patient may seek another assessment.*

Practitioner Signature	Date (YYYY / MM / DD)	Time

7. DISCONTINUATION OF PLANNING FOR MAiD

Indicate reason and fax this form along with the HLTH 1632 Request for MAiD to the Ministry of Health (778-698-4678) and appropriate Health Authority (if required):

◯ Patient **withdrew request** (select all that apply): ☐ Palliative measures are sufficient ☐ Changed their mind ☐ Other, specify: _____
☐ Family members do not support ☐ Do not know

◯ Patient's **capability deteriorated** (no longer capable of providing informed consent)

◯ **Death occurred prior to administration**: Date of death (YYYY/MM/DD) _____ ☐ Do not know

Date of Discontinuation (YYYY/MM/DD)	Name (Print)	Signature	Date Signed (YYYY/MM/DD)

Health Authority fax numbers for forms submission:

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@islandhealth.ca
Provincial Health Services Authority: Fax: 604-829-2631, maidcco@phsa.ca

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