



Medical Assistance in Dying ASSESSMENT RECORD (PRESCRIBER)

If MAiD is administered, Prescriber must fax all required forms to the BC Ministry of Health at 778-698-4678 and to the health authority MAiD Care Coordination Service (MCCS) (if required) within 72 hours of confirmation of patient's death. If assessment determines ineligibility, or if planning is discontinued, Prescriber must fax all forms to the Ministry of Health and MCCS (if required) within 30 days. Retain original in patient's health record.

1. PATIENT INFORMATION

Form section 1: Patient Information. Fields include Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Sex, Province or Territory that Issued PHN, and Postal Code Associated With PHN.

2. PRACTITIONER CONDUCTING ASSESSMENT

Form section 2: Practitioner Conducting Assessment. Fields include Last Name, First Name, Second Name, CPSID #, BCCNM #, Phone Number, Fax Number, Work Email Address, Work Mailing Address, City, and Postal Code. Includes a list of specialties with checkboxes.

3. RECEIPT OF WRITTEN REQUEST FOR MAiD

Form section 3: Receipt of Written Request for MAiD. Fields include Date Written Request Received, From whom did you receive the written request for MAiD?, and Yes/No to patient consultation.

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

Form section 4: Professional Interpreter. Fields include Last Name, First Name, ID Number, and Date of Service.

5. ELIGIBILITY CRITERIA AND RELATED INFORMATION

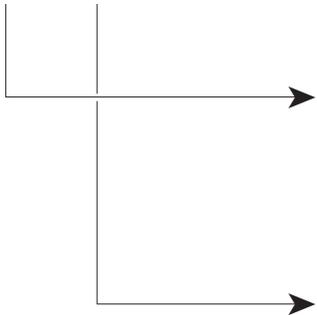
Each assessing medical practitioner or nurse practitioner is to make these determinations independently, document in the health record, and summarize their findings below. Comments for any matter in any section are clarified in the medical record.

Form section 5: Eligibility Criteria. Fields include Assessment Date, In Person/By Telemedicine, Patient Location at Time of Assessment, and Other - specify.

I confirm that the following safeguards are met:

Form section 5: Safeguards. Includes checkboxes for patient consent, financial benefit, written request, independent witness, and date of request/witness. Includes a text box for family member steps.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
<p>I have determined that the patient has been fully informed of:</p>		
<p><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 expected outcome associated with taking the medication to be prescribed (i.e. patient expects to die when the medication is administered).</p>		
<p>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></p>		
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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="radio"/> Yes <input type="radio"/> No <input type="radio"/> Did Not Assess	Is the patient at least 18 years of age?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Did Not Assess	Is the patient capable of making this health care decision?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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? <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>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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 (e.g. frailty with a clinical score or severity, etc.) - 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="radio"/> Yes <input type="radio"/> No <input type="radio"/> Did Not Assess	Is the patient in an advanced state of irreversible decline?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Did Not Assess 	<p>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?</p> <p>If Yes, indicate how the patient described their suffering (select all that apply):</p> <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: 	
Other Information		
<input type="radio"/> Yes <input type="radio"/> No 	<p>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)?</p> <p>If Yes, indicate what type of professional you consulted (select all that apply):</p> <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="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do Not Know 	<p>Has the patient received palliative care?</p> <p><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></p> <p>If Yes, for how long?</p> <ul style="list-style-type: none"> <input type="radio"/> Less than 2 weeks <input type="radio"/> 2 weeks to less than 1 month <input type="radio"/> 1-6 months <input type="radio"/> More than 6 months <input type="radio"/> Do not know <p>If No, to the best of your knowledge or belief, was palliative care accessible to the patient?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know</p>	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do Not Know 	<p>Does the patient require disability support services?</p> <p><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></p> <p>If Yes, has the patient received disability support services?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do Not Know</p> <p>If Yes, for how long?</p> <ul style="list-style-type: none"> <input type="radio"/> Less than 6 months <input type="radio"/> 6 months to less than 1 year <input type="radio"/> 1 year to less than 2 years <input type="radio"/> 2 years or more <input type="radio"/> Do not know <p>If No, to the best of your knowledge or belief, were disability support services accessible to the patient?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do Not Know</p>	

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 to medical assistance in dying.

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

Name of Practitioner Performing Determination of Capability →

Was a 1635 Consultant's Assessment of Patient's Informed Consent Decision Capability Form completed by another practitioner?

Yes No

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

The 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

The 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, and:

→ I have discussed and agree with the patient that they have appropriately considered reasonable means of alleviating their suffering.

→ I ensured counselling, mental health supports, disability supports, community services and palliative care has been offered in consultation with relevant professionals, as available and applicable.

→ Indicate the date on which the 90 clear days assessment period began (date first assessment by either the assessor or prescriber began).
YYYY / MM / DD

OR

The patient does **NOT** meet ALL the criteria for medical assistance in dying.

If, in your opinion, the patient is 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

Practitioner Signature	Date (YYYY / MM / DD)	Time	<i>If it is determined that the patient does not meet the eligibility criteria, the assessing practitioner is to notify the patient of their conclusion and that the patient may seek another assessment.</i>
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7. DISCONTINUATION OF PLANNING FOR MAiD

Indicate the reason and fax this form along with the HLTH 1632 Request for MAiD, and any other completed Assessment Records to the Ministry of Health (778-698-4678) and appropriate Health Authority (if required).

Patient **withdrew request**

If the patient withdrew request, what were their reasons (select all that apply):

- Palliative measures are sufficient
 Changed their mind
 Other - specify: _____
 Family members do not support MAiD
 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?

Yes No

Patient's **capability deteriorated** (no longer capable of providing informed consent) → Planned date of MAiD if known (YYYY/MM/DD): _____

Death occurred prior to administration → Planned date of MAiD if known (YYYY/MM/DD): _____

Did you complete the medical certificate of death?

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? _____

No → Provide the date of death (YYYY / MM / DD): _____ Do not know

Date of Discontinuation (YYYY/MM/DD)	Name (Print)	Signature	Date Signed (YYYY/MM/DD)
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Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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8. PLANNING FOR MEDICAL ASSISTANCE IN DYING

Your patient may be eligible to be an organ/tissue donor (exclusion criteria for organ and tissue donation can be found on the BCT/EB referral intake form). If your patient is interested in exploring organ donation with BC Transplant, please complete the BCT/EB referral intake form.

FORM: <http://www.transplant.bc.ca/health-professionals/organ-donation-resources/organ-donation-after-maid>

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: Medical Practitioner OR Nurse Practitioner

Date Other Practitioner Signed Second Assessment (YYYY/MM/DD)	Name of Other Medical Practitioner or Nurse Practitioner
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I was satisfied that the other medical practitioner or nurse practitioner and I are independent.

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 prescribing medical practitioner or nurse practitioner)

***Advanced consent is required to be completed with the patient immediately prior to patient self administering (Page 6)**

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

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

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.

9. PLANNING FOR MEDICAL ASSISTANCE IN DYING (If patient's death is NOT reasonably foreseeable)

I have ensured I or the other assessor who determined eligibility had 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:

Prescriber Assessor Other → If Other, Name of Practitioner:

I ensured that there were at least **90 clear days** between the date of the first MAiD assessment (day 0) and the day on which MAiD was provided (**day 91 or later**).

OR

The second assessor and I agreed to shorten the 90 clear day period, as the patient was at imminent risk of losing capacity to provide consent to MAiD.

10. WAIVER OF FINAL CONSENT (ONLY applicable when patient's death IS reasonably foreseeable)

The patient met all eligibility criteria and safeguards, and I have informed the patient of the risk of losing capacity to provide consent to receive medical assistance in dying.

Yes No

The patient and I have a written arrangement in place to waive final consent (HLTH 1645 Waiver of Final Consent) and the arrangement was made prior to the day the patient lost capacity to consent to receive medical assistance in dying, and before the Agreed Date of MAiD Provision on the arrangement.

Yes No

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
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Complete section 10 or section 11 IMMEDIATELY prior to medical assistance in dying unless the patient lost capacity to consent and a waiver of final consent is in place.

11. PATIENT CONFIRMATION OF REQUEST AND CONSENT (INTRAVENOUS ADMINISTRATION)

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.

PATIENT SIGNATURE

Signature of Patient	Date Signed (YYYY / MM / DD)
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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 Request for MAiD. **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.**

PROXY SIGNATURE (IF APPLICABLE) By signing below I confirm I signed in front of the Requestor and I meet ALL the above criteria to sign as the proxy.

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.

OR

12. SELF ADMINISTRATION (PATIENT ADVANCE CONSENT TO PRACTITIONER ADMINISTRATION of SECOND SUBSTANCE)

This written arrangement is **REQUIRED by federal legislation 241.2 (3.5) between the medical practitioner or nurse practitioner (MAiD Prescriber) and patient** for the MAiD Prescriber to administer a second substance to cause the patient's death in the event that the substance self administered by the patient does not have the expected outcome and the patient loses capacity to provide consent.

PATIENT INFORMATION	MAiD PRESCRIBER INFORMATION (Medical Practitioner or Nurse Practitioner)
Patient Full Name	MAiD Prescriber Full Name

By initialing and signing below I confirm that I agree to the terms set out in this arrangement in the event the self administration of the substance to cause the patient's death does not have the expected outcome.

Patient Initials	MAiD Prescriber Initials	The MAiD Prescriber and patient agree to the following terms:
Initials	Initials	The MAiD Prescriber will be present at the time the patient self administers the MAiD substance that will cause their death.
Initials	Initials	If, after self-administering the first substance, the patient loses the capacity to provide consent to receive medical assistance in dying but does not pass away within a specified period, the patient consents to the MAiD Prescriber administering a second substance to cause their death.
Initials	Initials	The MAiD Prescriber will administer the second dose after _____ minutes

PATIENT SIGNATURE	DATE PATIENT SIGNED	MAiD PRESCRIBER SIGNATURE
Patient Signature	YYYY / MM / DD	MAiD Prescriber Signature

13. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED AT ADMINISTRATION

Last Name	First Name	ID Number	Date of Service (YYYY / MM / DD)
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Last Name of Patient	First Name of Patient	Second Name(s) of Patient
14. ADMINISTRATION OF MEDICAL ASSISTANCE IN DYING		
Date (YYYY / MM / DD)	Location Address	
Location Type <input type="radio"/> Hospital (exclude palliative care beds or unit) <input type="radio"/> Community care facility (include long term care) <input type="radio"/> Palliative care facility (include hospital based palliative care beds/unit) <input type="radio"/> Assisted living residence <input type="radio"/> Hospice <input type="radio"/> Private residence (including patient's home) <input type="radio"/> Medical office or clinic <input type="radio"/> Other – specify: _____ <input type="radio"/> Ambulatory setting		
Was the patient transferred to a different facility for the provision of MAiD? <input type="radio"/> Yes <input type="radio"/> No ↳ If YES, was the transfer due to the originating facility's policy regarding MAiD provision? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do Not Know		
How was MAiD administered? <input type="radio"/> IV - complete section B or C below <input type="radio"/> Oral - complete section A below <input type="radio"/> Oral and IV - complete section A below		
A. PATIENT SELF ADMINISTERED ORAL MEDICATION AND PROVIDED SIGNATURE FOR ADVANCE CONSENT (If applicable)		
Did the patient self-administer the substance? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> I was present while the patient self administered the the first substance to cause their death. Did the patient die after self administering the first substance? <input type="radio"/> Yes <input type="radio"/> No ↳ <input type="checkbox"/> If No , I administered the second substance to cause the patient's death in accordance with the terms within the advance consent.		
B. PATIENT HAD CAPACITY TO PROVIDE EXPRESS CONSENT (if applicable)		
<input type="checkbox"/> Immediately before providing MAiD, I gave the patient an opportunity to withdraw their request and ensured that the patient gave express consent to receive MAiD.		
<input type="checkbox"/> If the patient had difficulty communicating, I took all the necessary measures to provide a reliable means by which the patient could have understood the information that was provided to them and communicated their decision.		
C. PATIENT PROVIDED DATE AND SIGNATURE FOR WAIVER OF FINAL CONSENT, THEN LOST CAPACITY (if applicable)		
<input type="checkbox"/> The patient lost capacity to consent to receiving MAiD and the waiver of final consent waiver is included with the forms.		
<input type="checkbox"/> I ensured the patient did not, by words, sounds or gestures, demonstrate refusal or resistance to having the substance administered.		
<input type="checkbox"/> I ensured the substance was administered to the patient in accordance with the terms of the Waiver of Final Consent.		
Supplementary Information – Provide supplementary information to clarify your responses, if applicable. <i>If more space is required please attach an additional page.</i>		
15. PRACTITIONER SIGNATURE		
Practitioner Signature	Date (YYYY / MM / DD)	Time

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.

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