PATIENT RECORD FOR REQUEST FOR MEDICAL ASSISTANCE IN DYING

PATIENT INSTRUCTIONS

Eligibility Criteria
A person may receive medical assistance in dying only if they meet all of the following criteria:

(a) they are eligible for health services funded by a government in Canada (or would be eligible following any applicable minimum period of residence or waiting period);

(b) they are at least 18 years of age and capable of making decisions about their health;

(c) they have a grievous and irremediable medical condition (see definition below);

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Filling in the Form
You cannot fill in this form until your physician or nurse practitioner determines that you have a "grievous and irremediable" condition. A grievous and irremediable medical condition is where a physician or nurse practitioner assesses a person and finds that him/or her meet the following criteria:

- have a serious and incurable illness, disease or disability;
- are in an advanced state of irreversible decline in capability;
- the illness, disease or disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Meeting the Safeguards
Safeguards must further be met before you will qualify for MAID. These include:

- Assessments by two independent physicians and/or nurse practitioners who are determining whether the patient meets the eligibility criteria set out in the legislation.
- Ensuring the patient expressly consents to medical assistance in dying and has made a signed and witnessed request, after being informed by their physician or nurse practitioner that they have a grievous and irremediable condition.
- Ensuring that the patient knows they may withdraw their request at any time.
- A physician or nurse practitioner taking all measures to reliably communicate with a patient should they have difficulty in communicating.
- Requiring a mandatory reflection period before medical assistance in dying is provided. This is normally 10 "clear days", which means both the day on which the request was signed and the day on which medical assistance in dying is provided are excluded. If the two physicians and/or nurse practitioners are of the opinion that the person's death or loss of their capacity to provide informed consent is imminent, then a shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances may be considered.
- Immediately before providing the patient with medical assistance in dying, the patient has the opportunity to withdraw their request and the patient gives express consent to receive medical assistance in dying.

PATIENT RECORD FOR REQUEST FOR MEDICAL ASSISTANCE IN DYING

This form is to be completed and signed by the patient and witnesses after the practitioner has confirmed that the patient has a grievous and irremediable medical condition.

PATIENT INFORMATION			
Last Name	First Name	Middle Name	Date of Birth (YYYY-MM-DD)
MEDICAL DIAGNOSIS relevant to request for Medical Assistance in Dying		Sex ☐ Male ☐ Female	Canadian Health Care No.

I, _____ (print full name), am at least 18 years old and I am requesting medical assistance in dying.

My medical practitioner or nurse practitioner has informed me that I have a grievous and irremediable medical condition (my "**Grievous and Irremediable Medical Condition**") that is:

(a) a serious and incurable illness, disease, or disability;

(b) is in an advanced state of irreversible decline in capability; and

(c) will result in my natural death in a reasonably foreseeable length of time taking into account all of my medical circumstances; and

My illness, disease or disability or the state of decline is causing me enduring physical or psychological suffering that is intolerable to me and cannot be relieved under conditions that I consider acceptable.

My medical practitioner or nurse practitioner has discussed with me the options available to me for treatment or sympton control of my Grievous and Irremediable Condition, including information about palliative care, in a manner that I understand and have considered. This discussion has included options that may improve my quality of life before my natural death by relieving my physical and psychological suffering.

I have received responses from my medical practitioner or nurse practitioner to all of my questions and requests for additional information about my Grievous and Irremediable Medical Condition and my treatment and care options.

My medical practitioner or nurse practitioner and I have discussed all of the risks and consequences of taking prescribed medications to end my life, including complications that may arise and affect my planned death.

Based on all of the information available to me, I am giving my informed consent that my medical practitioner or nurse practitioner prescribe medications to me that will end my life and work with me to make a plan to administer those medications to me or allow me to take them myself.

My request for medical assistance in dying is entirely voluntary and is being made without any external pressure.

I fully understand the impact of my request for medical assistance in dying and I understand that I am expected to die when the prescribed medications are administered to me or when I take them.

I understand that **I have the right to withdraw this request f**or medical assistance in dying at any time and in any manner before the medications are administered to me.

_____ _____

Patient's Signature Date (YYYY-MM-DD)

_____ _____ _____

Proxy Signature* Print Name Date (YYYY-MM-DD)

***Proxy may initial, sign and date this record on the patient's behalf only if:** (a) the patient is physically unable to do so and has given the proxy an express direction to initial, sign and date on their behalf, and they are in the presence of the patient; (b) they are at least 18 years old; (c) they understand the nature of the request for medical assistance in dying; (d) they do not know or believe that they are beneficiary under the will of the patient, or will be a recipient in any other way of a financial or other material benefit resulting from the patient's death; and (e) they are not also signing and dating this record as an independent witness.

DECLARATION OF INDEPENDENT WITNESSES

By ***initialing*** and ***signing*** below, I declare that I am at least 18 years of age and understand the nature of the request for medical assistance in dying, and that:

Witness 1 Initials	Witness 2 Initials	
		1. I have confirmed the identity of the patient that is completing this record to request medical assistance in dying;
		2. I do not know or believe that I am a beneficiary under the will of the patient or a recipient in any other way of a financial or material benefit resulting from the patient's death;
		3. I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides;
		4. I am not directly involved in providing health care services to the patient; and
		5. I do not directly provide personal care to the patient; and
		6. The patient reviewed, initialed, signed and dated this request in my presence, or if the patient was unable to do so, the patient's proxy initialled, signed and dated this request on the patient's behalf in my presence and in the presence of the patient under the express direction of the patient.

WITNESS 1

Printed Name	Signature	Date (YYYY/MM/DD)
Street	City, Province, Postal Code	Phone #

WITNESS 2

Printed Name	Signature	Date (YYYY/MM/DD)
Street	City, Province, Postal Code	Phone #