PRACTITIONER (PHYSICIAN OR NURSE PRACTITIONER)
RECORD FOR MEDICAL ASSISTANCE IN DYING

PLEASE PRINT

A 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.

B PRACTITIONER INFORMATION

Last Name	First Name	Middle Name	Phone Number ( )
Mailing Address		City	Postal Code
Registration #		I am a ☐ medical practitioner ☐ nurse practitioner	

☐ I am independent of the patient, in that I do not know or believe that I am:

- a beneficiary under the will of the patient;
- a recipient, in any other way, of a financial or other material benefit resulting from the patient's death (other than standard compensation for the services I provide relating to this request); and
- otherwise connected to the patient in a manner that could affect my objectivity.

Initial by Practitioner

C PRACTITIONER ELIGIBILITY ASSESSMENT

ASSESSMENT OF ELIGIBILITY CRITERIA (Indicate completion of eligibility assessment by checking each of the boxes. Each medical practitioner must independently complete this assessment.)

Date of first request for medical assistance in dying (YYYY-MM-DD)

Stated Reason for Request:

1 ☐ The patient is at least 18 years of age.

2 ☐ The patient is (or would be except for any applicable minimum period of residence or waiting period), eligible for health services funded by a government in Canada.

3 ☐ The patient has a grievous and irremediable medical condition which means that:

- the patient has a serious and incurable illness, disease, or disability;
- the patient is in an advanced state of irreversible decline in capability;
- the patient's illness, disease or disability or their state of decline causes them enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that they consider acceptable; **and**
- the patient's 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 (the "**Grievous and Irremediable Medical Condition**").

I have informed the patient that they have a "Grievous and Irremediable Medical Condition" on _____.
Date (YYYY-MM-DD)

Practitioner must provide patient with a diagnosis of a "Grievous and Irremediable Medical Condition" before patient can complete a request form.

Patient Name

4 The patient must be capable of making decisions with respect to their health.

- Capable means that a patient understands the nature, purpose, benefits, risks, and foreseeable consequences of a health care decision and understands that the information applies to him or her.

Check one of the following:

☐ **A.** I have determined that the patient **is not** suffering from a psychiatric or psychological disorder causing impaired judgment, and has capacity to give informed consent;

☐ **B.** I have determined that the patient **is** suffering from a psychiatric or psychological disorder causing impaired judgment, does not have the capacity to give informed consent and is not eligible for medical assistance in dying; or

☐ **C.** I have referred the patient to the provider listed below for evaluation and counselling for a possible psychiatric or psychological disorder causing impaired judgment and **have attached the consultant's completed evaluation.**

Consulting Practitioner's Information:

Last Name	First Name	Phone Number ( )	Date (YYYY-MM-DD)

5 ☐ The patient has been fully informed of:

- their medical diagnosis relating to the Grievous and Irremediable Medical Condition;
- their prognosis relating to the Grievous and Irremediable Medical Condition;
- the feasible alternatives and options for treatment or sympton control of the Grievous or Irremediable Medical Condition, including, but not limited to, information about end-of-life or palliative care options that are available to relieve their physical or psychological suffering;
- the potential risks and probable consequences, including but not limited to death and any other complications associated with the medications to be prescribed; **and**
- that the expected result of being administered the prescribed medications is death.

6 ☐ The patient has had an opportunity to ask questions and to request additional information about their Grievous and Irremediable Medical Condition and treatment and care options, and has received responses to all of those questions and requests.

7 ☐ The patient has made a voluntary request for medical assistance in dying that, in particular, was not made as a result of any external pressure.

8 ☐ The patient has given their informed consent to receive medical assistance in dying. The *Care Consent Act* s. 5 defines consent in Yukon.

9 ☐ The patient has been informed of his or her right to withdraw his or her request for medical assistance in dying at any time.

I have assessed this patient and confirm that the patient meets the eligibility requirements for MAID ☐ Yes ☐ No

Practitioner Signature _____ Date (YYYY-MM-DD) _____

Patient Name

Additional Comments Regarding Eligibility Assessment
(If comments in any section exceed the space provided, please use an attached page.)

2B SECOND PRACTITIONER'S INFORMATION

Last Name	First Name	Middle Name	Phone Number ( )
Mailing Address		City	Postal Code
Registration #		I am a ☐ medical practitioner ☐ nurse practitioner	

☐ I am independent of the patient, in that I do not know or believe that I am:

- a beneficiary under the will of the patient;
- a recipient, in any other way, of a financial or other material benefit resulting from the patient's death (other than standard compensation for the services I provide relating to this request); and
- otherwise connected to the patient in a manner that could affect my objectivity.

☐ I am independent of the other practitioner, in that I do not know or believe that I am:

- a mentor or responsible for supervising their work; and
- otherwise connected to the other practitioner in any other way that could affect my objectivity.

Initial of 2nd Practitioner

Patient Name

2C SECOND PRACTITIONER ELIGIBILITY ASSESSMENT

SECOND ASSESSMENT OF ELIGIBILITY CRITERIA (Indicate completion of second eligibility assessment by checking each of the boxes. The second medical practitioner must independently complete this assessment.)

		Date of first request for medical assistance in dying (YYYY-MM-DD)
		Stated Reason for Request:
1	☐	The patient is at least 18 years of age.
2	☐	The patient is (or would be except for any applicable minimum period of residence or waiting period), eligible for health services funded by a government in Canada.
3	☐	The patient has a grievous and irremediable medical condition which means that: • the patient has a serious and incurable illness, disease, or disability; • the patient is in an advanced state of irreversible decline in capability; • the patient's illness, disease or disability or their state of decline causes them enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that they consider acceptable; **and** • the patient's 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 (the "**Grievous and Irremediable Medical Condition**").
4		The patient must be capable of making decisions with respect to their health. • Capable means that a patient understands the nature, purpose, benefits, risks, and foreseeable consequences of a health care decision and understands that the information applies to him or her. **Check one of the following:**
	☐	**A.** I have determined that the patient **is not** suffering from a psychiatric or psychological disorder causing impaired judgment, and has capacity to give informed consent;
	☐	**B.** I have determined that the patient **is or may be** suffering from a psychiatric or psychological disorder causing impaired judgment, does not have the capacity to give informed consent and I will communicate my assessment to the other practitioners for further evaluation.
5	☐	The patient has been fully informed of: • their medical diagnosis relating to the Grievous and Irremediable Medical Condition; • their prognosis relating to the Grievous and Irremediable Medical Condition; • the feasible alternatives and options for treatment or sympton control of the Grievous or Irremediable Medical Condition, including, but not limited to, information about end-of-life or palliative care options that are available to relieve their physical or psychological suffering; • the potential risks and probable consequences, including but not limited to death and any other complications associated with the medications to be prescribed; **and** • that the expected result of being administered the prescribed medications is death.

Patient Name

6	☐	The patient has had an opportunity to ask questions and to request additional information about their Grievous and Irremediable Medical Condition and treatment and care options, and has received responses to all of those questions and requests.
7	☐	The patient has made a voluntary request for medical assistance in dying that, in particular, was not made as a result of any external pressure.
8	☐	The patient has given their informed consent to receive medical assistance in dying. The *Care Consent Act* s. 5 defines consent in Yukon.
9	☐	The patient has been informed of his or her right to withdraw his or her request for medical assistance in dying at any time.

I have assessed this patient and confirm that the patient meets the eligibility requirements for MAID ☐ Yes ☐ No

_____ _____

Second Practitioner Signature | Date (YYYY-MM-DD)

Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with the *Criminal Code* and any applicable territorial laws, rules or standards.

Additional Comments Regarding Eligibility Assessment

(If comments in any section exceed the space provided, please use an attached page.)

Patient Name

D MANDATORY SAFEGUARDS

MANDATORY SAFEGUARDS

Indicate completion of mandatory safeguards by checking each of the boxes. The medical practitioner must ensure these safeguards are satisfied.

1	☐	I am of the opinion that the patient meets all of the eligibility criteria set out above in Section C (Medical Practitioner Eligibility Assessment) and is specifically capable of making decisions with respect to their health including, but not limited to, their request for medical assistance in dying.
2	☐	I have obtained a written opinion from another independent practitioner that confirms that the patient meets all of the eligibility criteria set out above in Section C (Practitioner Eligibility Assessment). See 2C for the Second Practitioner's Eligibility Assessment.
3	☐	After having been informed of their Grievous and Irremediable Medical Condition the patient has voluntarily completed the Patient Record for Request for Medical Assistance in Dying by: • personally signing, and dating the Patient Record for Request for Medical Assistance in Dying; or • giving an express direction to another person (the proxy) to sign and date the Record for Request for Medical Assistance in Dying on their behalf and in their presence.
4	☐	The Patient Record for Request for Medical Assistance in Dying was signed and dated by the patient or the proxy, at the patient's express direction and in their presence, before two independent witnesses who also signed and dated the Record for Request for Medical Assistance in Dying.
5	☐	Where the patient has had difficulty in communicating, I the practitioner have taken all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision. ☐ N/A
6	☐	The patient has been informed of their right to withdraw their request for medical assistance in dying at any time and in any manner.
7	☐	A period of reflection of _____ days is planned between the date the Patient Record for Request in Medical Assistance in Dying was completed and signed by the patient and the date the medical assistance in dying will be provided. (A minimum of 10 clear days is required unless both practitioners are of the opinion that the patient's death or loss of capacity to provide informed consent is imminent then a shorter period as determined by the first medical practitioner or nurse practitioner that s/he considers appropriate in the circumstances. In calculating "clear days", both the day on which the request was signed and the day on which medical assistance in dying is provided are excluded.)
8	☐	I have informed the dispensing pharmacist that the substances I have prescribed pursuant to the patient's request for medical assistance in dying are intended for the purpose of providing medical assistance in dying.
9	☐	The patient will be given an opportunity immediately before the prescribed medications are administered to withdraw their request and any consent they have given for medical assistance in dying. The practitioner must ensure the patient gives their express consent to receive medical assistance in dying.

Patient Name

E MEDICATION PRESCRIBED

Date Prescribed (YYYY-MM-DD)	☐ Self-Administered ☐ Practitioner Administered MAID	Date Dispensed (YYYY-MM-DD)
Pharmacy Name		
Notes		

F MEDICATION ADMINISTRATION REQUIREMENTS

MEDICATION ADMINISTRATION REQUIREMENTS
To be completed by the Practitioner on the date the prescribed medication is to be administered before the medication is administered.

1	☐	A period of reflection of _____ clear days has elapsed between the day on which the Patient Record for Request in Medical Assistance in Dying was completed and the date on which the medical assistance in dying is being provided. In calculating "clear days", both the day on which the request was signed and the day on which medical assistance in dying is provided are excluded.
2	☐	All necessary measures have been taken to provide a reliable means of communicating with the patient up to the time immediately before medical assistance in dying is provided, to give them information they can understand about their request, and to confirm their decision regarding their request for medical assistance in dying.
3	☐	The patient is capable of confirming their request for medical assistance in dying and is capable of giving express informed consent to receive medications to end their life.
4	☐	The patient has been given the opportunity immediately prior to the administration of the prescribed medications to withdraw their request for medical assistance in dying and any consent they have previously given to receive medications to end their life in accordance with their request.
5	☐	The patient has clearly communicated and confirmed their request for medical assistance in dying and expressly consented to the administration of medications to end their life.
		Date of Administration (YYYY-MM-DD) _____ **OR** Time of Administration _____ ☐ N/A Self-Administered MAID
		Time of Death _____
		Patient Setting ☐ Private Residence ☐ Hospital ☐ Nursing Home

To the best of my knowledge, all of the requirements for medical assistance in dying under territorial and federal legislation have been met.

_____ _____

Practitioner Signature Date (YYYY-MM-DD)

Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with the *Criminal Code* and any applicable territorial laws, rules or standards.