



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 (if required). If the assessment determines ineligibility, or if planning is discontinued, Assessor MUST fax this form to the Ministry of Health at 778-698-4678 within 30 days. Retain original in patient's health record.

PATIENT INFORMATION

Form fields for Patient Information: Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Gender, Province or Territory that Issued PHN, Postal Code Associated With PHN.

PRACTITIONER CONDUCTING ASSESSMENT

Form fields for Practitioner Conducting Assessment: Last Name, First Name, Second Name, CPSID #, BCCNP Prescriber #, Phone Number, Fax Number, Work Email Address, Work Mailing Address, City, Postal Code.

Section for physician specialty: If you are a physician, what is your specialty? (Anesthesiology, Family Medicine, Geriatric Medicine, Neurology, Palliative Medicine, Other, Cardiology, General Internal Medicine, Nephrology, Oncology, Respiratory Medicine).

RECEIPT OF WRITTEN REQUEST FOR MAiD

Form fields for Receipt of Written Request for MAiD: From whom did you receive the written request for MAiD that triggered the obligation to provide information?, Date Written Request Received, Yes/No to patient consultation, Province or Territory where you received the written request for MAiD.

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Form fields for Professional Interpreter: Last Name, First Name, ID Number, Date of Service (YYYY / MM / DD).

ELIGIBILITY CRITERIA AND RELATED INFORMATION

Text: Each assessing medical 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 fields for Eligibility Criteria: Assessment Date (YYYY / MM / DD), In Person/By Telemedicine, If Telemedicine: Name of Witness (Regulated Health Professional), Witness Profession, Witness College ID, Location of Assessment (Home/Facility/Unit/Other).

I confirm that the following safeguards are met:

Checklist of safeguards: 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, 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 ensured that the patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person permitted to do so on their behalf. I was satisfied that the request was signed and dated by the patient, or by another person permitted to do so on their behalf, and before two independent witnesses who then signed and dated the request. I ensured that the request was signed and dated after the patient was informed by a practitioner that the patient had a grievous and irremediable medical condition.

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
I have determined that the patient has been fully informed of:		
<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 recommendation to seek advice on life insurance implications.		
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>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient at least 18 years of age?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient capable of making this health care decision?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 - 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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Is the patient in an advanced state of irreversible decline?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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): <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: 	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Assess	Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?	
Consideration of capability to provide informed consent. Check one of the following: <i>(Capable means that person is able to understand the relevant information and the consequences of their choices)</i>		
<input type="checkbox"/> I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying. OR <input type="checkbox"/> I have reason to be concerned about the capability of the patient to provide informed consent. <input type="checkbox"/> I have referred the patient to another practitioner for an assessment of capability to provide informed consent.		
<div style="border: 1px solid black; padding: 5px; margin: 5px 0;">Name of Practitioner Performing Determination of Capability</div>		
On receipt of the requested assessment, I determine that the patient: <input type="checkbox"/> is capable of providing informed consent <input type="checkbox"/> is not capable of providing informed consent		
CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE		
I determine that the patient: <input type="checkbox"/> Does meet ALL the criteria for medical assistance in dying <input type="checkbox"/> Does NOT meet ALL the criteria for medical assistance in dying <i>If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.</i>		
Practitioner Signature	Date (YYYY / MM / DD)	Time
If planning was discontinued prior to administration, indicate reason:		
<input type="checkbox"/> Patient withdrew request <input type="checkbox"/> Patient's capability deteriorated (no longer capable of providing informed consent) <input type="checkbox"/> Death occurred prior to administration		
Health Authority fax numbers for submission of forms: Fraser HA: Fax: 604-523-8855 Vancouver Coastal HA: Fax: 1-888-865-2941 Interior HA: Fax: 250-469-7066 Vancouver Island HA: Fax: 250-519-3669 Northern HA: Fax: 250-565-2640 Provincial Health Services Authority: Fax: 604-829-2631		