BRITISH COLUMBIA | Ministry of Health

Medical Assistance in Dying

ASSESSMENT RECORD (PRESCRIBER)

Patient Label

For cases involving a health authority (HA), fax or mail a copy of this Assessment to applicable HA (pg 2). Retain original in patient's health record. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN)	Birthdate (YYYY / MM / DD)	Gender ☐ Male ☐ Female ☐ Other - specify:

Medical Diagnosis Relevant to Request for Assisted Death

PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

CPSID #	OR	CRNBC Prescriber #	Phone Number

Mailing Address	City	Postal Code

Location of Assessment
☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:

Initials	I have been contacted by the patient or another colleague and agree to be an assessor. **I am prepared to be the prescriber** concerning this patient's request for medical assistance in dying.

CONFIRMATION OF ELIGIBILITY AND INFORMED CONSENT

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

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 their option to seek another opinion.

Patient Diagnosis

Patient Prognosis

Assessment Was Conducted

☐ In Person	Date of Assessment			
☐ By Telemedicine	Date of Assessment	Name of Witness - Regulated Health Professional	Profession	College ID

By initialing and signing, I confirm that:

Initials	The patient is personally known to me or has provided proof of identity, and has consented to this assessment.
Initials	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.
Initials	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
Initials	I am satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.
Initials	The patient's request for medical assistance in dying was signed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
Initials	The other assessor and I are not each other's mentor or supervisor, and I do not know or believe that I am connected to the other assessor or to the patient in any other way that would affect my objectivity.

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

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

- Their medical diagnosis and prognosis.
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- Their right to withdraw their request at any time and in any manner.
- The potential risks associated with taking the medication to be prescribed.
- The probable outcome/result of taking the medication to be prescribed.
- The recommendation to seek advice on life insurance implications.

I have determined that the patient meets all of the criteria to be eligible for medical assistance in dying:

Initials	The patient is eligible for health services funded by a government in Canada.
Initials	The patient is at least 18 years of age.
Initials	The patient is capable of making this health care decision.
Initials	The patient has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the patient considers acceptable. The patient is in an advanced state of irreversible decline and natural death is reasonably foreseeable.
Initials	The patient has made a voluntary request for medical assistance in dying that was not made as a result of external pressure.
Initials	After having been informed of the means that are available to relieve their suffering, including palliative care, the patient has given informed consent to receive medical assistance in dying.

Consideration of capability to provide informed consent. Initial one of the following:
(Capable means that person is able to understand the relevant information and the consequences of their choices)

Initials	I have **no reason** to believe the patient is incapable of providing informed consent to medical assistance in dying.

OR

Initials	I have **reason to be concerned** about capability and 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
	On receipt of the requested assessment, I determine that the patient: ☐ is capable of providing informed consent ☐ is **not** capable of providing informed consent

CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

I determine that the patient:

☐ Does meet the criteria for medical assistance in dying ☐ Does **not** meet the criteria for medical assistance in dying

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.

Practitioner Signature	CPSID #	OR	CRNBC Prescriber #	
	Date			Time

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

Health Authority fax numbers for submission of forms:

FHA:	Fax: 604-523-8855	**NHA:**	Fax: 250-565-2640	**VIHA:**	Fax: 250-727-4335
IHA:	Fax: 250-469-7066	**VCHA:**	Fax: 1-888-865-2941	**PHSA:**	Fax: 604-829-2631

For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1632. http://www2.gov.bc.ca/assets/gov/health/forms/1632.pdf

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

PLANNING FOR MEDICAL ASSISTANCE IN DYING

Initials	I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for medical assistance in dying.
Initials	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 practitioner)
Initials	I have planned for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)
Initials	A location and timeline for provision. Planned Location ☐ Home ☐ Facility - Site: Unit: ☐ Other - specify: Planned Date | Days From Initial Request If intended date is less than 10 days from initial request, the assessor, the patient and I are in agreement that: ☐ Death is imminent, or ☐ The patient's loss of capacity to provide informed consent is imminent.
Initials	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 48 hours after confirmation of death.
Initials	I have indicated on the prescription or order that the medication is for medical assistance in dying.

If planning was discontinued prior to administration, indicate reason and submit this form to the appropriate Health Authority.

☐ Patient withdrew request
☐ Patient's capability deteriorated (no longer capable of providing informed consent)
☐ Death occurred prior to administration

ADMINISTRATION OF MEDICAL ASSISTANCE IN DYING

Date (YYYY / MM / DD)	Location ☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:
Location Address	

Initials	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw their request and gave express informed and voluntary consent to receive medical assistance in dying (pg 3, Patient Request Record).
Initials	The medication was administered via the method chosen by patient: ☐ Practitioner-administered Intravenous (IV) Regimen ☐ Patient self-administered Oral Regimen (supervised by practitioner) ☐ Practitioner administered IV backup kit _______ hours after ineffective self-administration Medication Administered | Interval Between Administration and Confirmation of Death

PRACTITIONER SIGNATURE

Practitioner Signature	CPSID #	OR	CRNBC Prescriber #
	Date		Time

VSA 406A Medical Certification of Death

A medical or nurse practitioner must complete the Medical Certification of Death within 48 hours of death in compliance with Section 18 of the *Vital Statistics Act* and provide the completed form to the Funeral Director so that a Disposition Permit may be issued.

To order additional VSA 406A forms, fax or email the Vital Statistics Agency. Stockroom Fax: 250 952-9094. Email: HLTH.VSStock@gov.bc.ca