BRITISH COLUMBIA | Ministry of Health

Medical Assistance in Dying

PATIENT REQUEST RECORD

Patient Label

For cases involving a health authority (HA), when this Patient Request is first documented fax or mail a copy 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:

Patient's Home / Residence Address

Medical Diagnosis Relevant to Request for Assisted Death

Location at Time of Request

☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:

PATIENT REQUEST

By initialing and signing below, I confirm that:

Initials	I am at least 18 years of age and I request medical assistance in dying. I make this request voluntarily and without pressure from others.
Initials	I believe that my medical condition is grievous and irremediable, my suffering is intolerable, there are no treatments that I consider acceptable, I am in an advanced state of irreversible decline, and my death is reasonably foreseeable.
Initials	I have been fully informed of my diagnosis and prognosis and of options for treatments towards cure or control of my condition/disease, that may be applicable to my circumstances.
Initials	Treatments for symptom control, including the potential benefits of palliative care or other treatment, have been described to me in a manner that I understand.
Initials	I consent to be assessed for eligibility and capability by one or more colleagues of my medical or nurse practitioner (practitioner) and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.
Initials	I understand that my practitioner will confirm with me whether my request is to take prescribed medication(s) that I may self-administer orally or that a practitioner will administer medications to me by intravenous injection.
Initials	I understand that if I choose self-administration and the regimen is not effective within a reasonable period of time, as determined by me and my practitioner, my practitioner will administer intravenous medication to fulfil my request.
Initials	I have had an opportunity to ask questions and to request additional information, and have received answers to any questions and responses to any requests.
Initials	I understand that I have the right to change my mind at any time.
Initials	I expect to die when the medication to be prescribed is administered.

PATIENT SIGNATURE FOR INITIAL REQUEST (must be signed in front of the two independent witnesses listed on page 2)

Signature of Patient	Print Name	Date Signed

PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the patient and the two independent witnesses listed on page 2)

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 cannot be either of the witnesses listed on page 2 of this request form. 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 and witnesses.

Signature of Proxy	Print Name	Relationship
	Date Signed	Phone Number

Address	City	Province	Postal Code

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

CONFIRMATION OF INDEPENDENT WITNESSES

By initialing and signing below, I confirm that:

Witness 1	Witness 2	
Initials	Initials	I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
Initials	Initials	The patient is personally known to me or has provided proof of identity.
Initials	Initials	The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other witness.
Initials	Initials	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.
Initials	Initials	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.
Initials	Initials	I am not directly involved in providing health care services to the patient.
Initials	Initials	I do not directly provide personal care to the patient.

SIGNATURE OF INDEPENDENT WITNESSES (must be signed in the presence of the patient and the other witness)

WITNESS 1

Signature of Witness 1	Print Name	Date Signed	Phone Number	
	Street Address and City		Province	Postal Code

WITNESS 2

Signature of Witness 2	Print Name	Date Signed	Phone Number	
	Street Address and City		Province	Postal Code

NEAREST RELATIVE (OPTIONAL)

Name of Nearest Relative	Relation	Contact Number

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

DO NOT COMPLETE the section below until immediately prior to medical assistance in dying.

PATIENT CONFIRMATION OF REQUEST AND CONSENT IMMEDIATELY PRIOR TO MEDICAL ASSISTANCE IN DYING

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.

Signature of Patient	Print Name	Date Signed

PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of patient)

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 cannot be either of the witnesses listed on page 2 of this request form. 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.

Signature of Proxy	Print Name	Relationship
	Date Signed	Phone Number

Address	City	Province	Postal Code

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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