

1632

Medical Assistance in Dying PATIENT REQUEST RECORD

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Patient Label

Patient: submit this form to your doctor or nurse practitioner, or MAiD Care Coordination Service. Practitioner: if required, fax or mail a **COPY** of this form to the applicable health authority MAiD CCS. See page 2 for MAiD Care Coordination Service contact information.

PATIENT INF	ORMATION										
Last Name		First Name		Second Name(s)							
Personal Health Number (PHN) Birthdate (Y		Birthdate (YYYY / MM / DD)	Gender Male Female Other - specify:								
Patient's Home / Residence Address		1	Postal Code		Phone Number						
Medical Diagnos	is Relevant to Request for	Medical Assistance in Dying									
Location at Time of Request Home Facility/Other (specify):			Primary Health Care Provide	Phone Number							
PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED											
Last Name		First Name	ID Number	Date o	of Service (YYYY / MM / DD)						
PATIENT REQ	UEST										
	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 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	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	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 a medical or nurse practitioner(s) 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 information will be shared with other health professionals involved in my care and as required by law.										
Initials	I have had an opportunity to ask questions and request information, and I understand that I may continue to ask questions and seek additional information.										
Initials	I expect to die when the medication to be prescribed is administered.										
Initials											
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 Sign	Date Signed (YYYY / MM / DD)						
PROXY SIGNATU	JRE (IF APPLICABLE) (mu	ust be signed in front of the patient and t	he two independent witness	ses listed on page	e 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	Print Name		Relationship to Patient						
		Date Signed (YYYY / MI	Date Signed (YYYY / MM / DD)		Phone Number						
Address		I	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 INDEPEND	ENT WITNESSES (m	ust be signe	d in the p	resence of the patie	nt and the otl	ner witne	ess)					
WITNESS 1			T =		ı								
Signature of Witness 1			Print Name		Relationship to Patient								
			Date Signed (YYYY / MM / DD)		Phone Number								
Address			City			Province	Postal Code						
WITNESS 2				' ·									
Signature of Witness 2			Print Name		Relationship to Patient								
			Date Signed (YYYY / MM / DD)		Phone Number								
Address			City			Province	Postal Code						
PREFERRED	CONTACT FOR	R PATIENT											
Name of Preferr			Relationship to Patient		Phone Number								

The Patient Request Record is now complete. Submit this form to your physician or nurse practitioner, or you can contact your health authority's care coordination service for medical assistance in dying (contact information below).

Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see:

https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms

Fraser Health Authority

Phone: 604-587-7878, Fax: 604-523-8855

Interior Health Authority

Phone: 1-844-469-7073, Fax: 250-469-7066

Northern Health Authority

Phone: 250-645-6417, Fax: 250-565-2640

Vancouver Coastal Health Authority

Phone: 1-844-550-5556, Fax: 1-888-865-2941

Vancouver Island Health Authority

Phone: 1-877-370-8699, Fax: 250-727-4335

Provincial Health Services Authority

Phone: 1-888-875-3256, Fax: 604-829-2631

This information is collected by the Ministry of Health under s.26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPP Act) and will be used for the purposes of monitoring and oversight for the provision of Medical Assistance in Dying in British Columbia. Should you have any questions about the collection of this personal information, please contact the Manager, Medical Assistance in Dying Oversight Unit at PO BOX 9638 STN PROV GOVT, Victoria BC V8W 9P1; 778-698-7497.