



Medical Assistance in Dying ASSESSMENT RECORD (ASSESSOR)

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Patient Label

Assessor is to fax or mail a COPY of this assessment to the applicable health authority (see 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

Form with fields: Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate (YYYY / MM / DD), Gender (Male, Female, Other - specify).

PRACTITIONER CONDUCTING ASSESSMENT

Form with fields: Last Name, First Name, Second Name, CPSID #, CRNBC Prescriber #, Phone Number, Fax Number, Email Address, Mailing Address, City, Postal Code.

PROFESSIONAL INTERPRETER (PLS OR OTHER) IF USED

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

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 the patient is determined to not meet the criteria, the practitioner assessor is to advise attending practitioner and patient of determination and of his or her option to seek another opinion.

Form with fields: Assessment Date (YYYY / MM / DD), In Person, By Telemedicine, If Telemedicine: Name of Witness (Regulated Health Professional), Witness Profession, Witness College ID.

Form with fields: Location of Assessment (Home, Facility - Site, Unit, Other - specify).

Patient Diagnosis (diagnoses that indicate a grievous and irremediable medical condition, intolerable suffering, and natural death has become reasonably foreseeable)

Patient Prognosis (estimated time to death, based on your professional opinion) with checkboxes for < 1 month, 1 - 3 months, 4 - 6 months, 7 months - 1 year, > 1 year.

By initialing and signing, I confirm that:

Table with 2 columns: Initials, Confirmation text. Contains 6 rows of confirmation statements.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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I have determined that the patient has been fully informed of:

- | | |
|---|---|
| <input type="checkbox"/> Their medical diagnosis and prognosis.
<input type="checkbox"/> The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
<input type="checkbox"/> Their right to withdraw their request at any time and in any manner. | <input type="checkbox"/> The potential risks associated with taking the medication to be prescribed.
<input type="checkbox"/> The probable outcome/result of taking the medication to be prescribed.
<input type="checkbox"/> 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	The patient has given informed consent to receive medical assistance in dying, after having been informed of the means that are available to relieve their suffering, including palliative care.

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.
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OR

Initials	I have reason to be concerned about capability and I have referred the patient to another practitioner for a determination of capability to provide informed consent to medical assistance in dying.
	Name of Practitioner Performing Determination of Capability
	On receipt of the requested opinion, 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:

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	Date (YYYY / MM / DD)	Time
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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

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:		For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1636. http://www2.gov.bc.ca/assets/gov/health/forms/1636.pdf
Fraser HA: Fax: 604-523-8855	Vancouver Coastal HA: Fax: 1-888-865-2941	
Interior HA: Fax: 250-469-7066	Vancouver Island HA: Fax: 250-727-4335	
Northern HA: Fax: 250-565-2640	Provincial Health Services Authority: Fax: 604-829-2631	