



Medical Assistance in Dying
PATIENT REQUEST RECORD

Patient Label

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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 INFORMATION

Form fields for Patient Information: Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Gender, Patient's Home / Residence Address, Postal Code, Phone Number, Medical Diagnosis, Location at Time of Request, Primary Health Care Provider.

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Form fields for Professional Interpreter: Last Name, First Name, ID Number, Date of Service.

PATIENT REQUEST

By initialing and signing below, I confirm that:

Confirmation statements with 'Initials' column: I am at least 18 years of age... I have been fully informed... I believe that my medical condition is grievous... Treatments for symptom control... I consent to be assessed... I understand that my information will be shared... I have had an opportunity to ask questions... I expect to die when the medication... I understand that I have the right to change my mind...

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.

Signature of Proxy, Print Name, Relationship to Patient, Date Signed, Phone Number

Address, City, Province, Postal Code

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

Name of Preferred Contact	Relationship to Patient	Phone Number
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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>

<p>Fraser Health Authority Phone: 604-587-7878, Fax: 604-523-8855</p> <p>Interior Health Authority Phone: 1-844-469-7073, Fax: 250-469-7066</p>	<p>Northern Health Authority Phone: 250-645-6417, Fax: 250-565-2640</p> <p>Vancouver Coastal Health Authority Phone: 1-844-550-5556, Fax: 1-888-865-2941</p>	<p>Vancouver Island Health Authority Phone: 1-877-370-8699, Fax: 250-727-4335</p> <p>Provincial Health Services Authority Phone: 1-888-875-3256, Fax: 604-829-2631</p>
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