www.westcoastad.ca info@westcoastad.ca
PHONE 778 265 9224 **FAX** 250 480 7339

REFERRAL FORM

□ **URGENT** □ **NON URGENT**

Must be included with Referral

□ **Patient Request Record**
□ **Assessment (Assessor) Record**
□ **Clinical Records (pertinent patient history)**

Referring Clinician: ___________________________ MSP#_____________________________

Phone #_____________________________ Fax#_____________________________

Family Physician (if different from referring GP): Dr.____

Patient Name: ____________________________________

DOB: ______________________________________

PHN: ______________________________________

Address: ___________________________________

Phone: ____________________________________

PATIENT LABEL

Main Contact: _________________________________ Phone#: ______________________________________

Location of Patient: □ home □ hospital □ hospice □ other ____

Primary Diagnosis: ____

Pertinent Patient Details eg. *Non-Verbal best contacted through family member*:

____

____

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West Coast Assisted Dying (WCAD) respects and upholds an individual's right to privacy and the protection of his or her personal information. **WCAD** is committed to ensuring compliance with the **Personal Information Protection Act – Bill 38.**

BRITISH COLUMBIA | Ministry of Health

1632

Patient Label

Medical Assistance in Dying

PATIENT REQUEST RECORD

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

Last Name	First Name	Second Name(s)

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

Patient's Home / Residence Address	Postal Code	Phone Number

Medical Diagnosis Relevant to Request for Medical Assistance in Dying

Location at Time of Request ☐ Home ☐ Facility/Other (specify):	Primary Health Care Provider (Name)	Phone Number

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name	First Name	ID Number	Date of Service (YYYY / MM / DD)

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 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	I understand that I have the right to change my mind at any time.

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 (YYYY / MM / DD)

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 to Patient
	Date Signed (YYYY / MM / DD)	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	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

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.

BRITISH COLUMBIA | Ministry of Health

1633

Patient Label

Medical Assistance in Dying

ASSESSMENT RECORD (ASSESSOR)

Assessor is to provide this assessment to the Prescriber (if known) and health authority MAiD Care Coordination Service (if required). **If the assessment determines ineligibility, or if planning is discontinued, Assessor MUST fax this form to the Ministry of Health at 778-698-4678 within 30 days.** Retain original in patient's health record.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

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

Province or Territory that Issued PHN *If patient does not have a PHN, provide the province or territory of patient's usual place of residence*	Postal Code Associated With PHN *If patient does not have a PHN, provide the postal code of patient's usual place of residence*

PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

☐ CPSID # ☐ BCCNP Prescriber #	Phone Number	Fax Number	Work Email Address

Work Mailing Address	City	Postal Code

If you are a physician, what is your specialty?

☐ Anaesthesiology ☐ Family Medicine ☐ Geriatric Medicine ☐ Neurology ☐ Palliative Medicine ☐ Other (specify)
☐ Cardiology ☐ General Internal Medicine ☐ Nephrology ☐ Oncology ☐ Respiratory Medicine

To the best of your knowledge or belief, before you received the written request for MAiD, did the patient consult you concerning their heath for a reason other than seeking MAiD? ☐ Yes ☐ No

Province or Territory where you received the written request for MAiD.

RECEIPT OF WRITTEN REQUEST FOR MAiD

From whom did you receive the written request for MAiD that triggered the obligation to provide information?

☐ Patient directly (1632 form) ☐ Patient directly - other, specify:
☐ Another practitioner ☐ Another third-party - specify:
☐ Care coordination service

Date Written Request Received (YYYY / MM / DD)

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name	First Name	ID Number	Date of Service (YYYY / MM / DD)

ELIGIBILITY CRITERIA AND RELATED INFORMATION

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

Assessment Date (YYYY / MM / DD)	☐ In Person ☐ By Telemedicine	If Telemedicine: Name of Witness (Regulated Health Professional)	Witness Profession	Witness College ID

Location of Assessment

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

I confirm that the following safeguards are met:

☐ The patient is personally known to me or has provided proof of identity, and has consented to this assessment.

☐ 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.

☐ I ensured that the patient's request for medical assistance in dying was made **in writing and signed and dated** by the patient or by another person permitted to do so on their behalf.

Indicate the date on which the patient (or other person) signed the request (YYYY / MM / DD): ____________________

☐ I was satisfied that the request was signed and dated by the patient, or by another person permitted to do so on their behalf, and before two independent witnesses who then signed and dated the request.

☐ I ensured that the request was signed and dated after the patient was informed by a practitioner that the patient had a grievous and irremediable medical condition.

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

Medical Assistance in Dying ASSESSMENT RECORD (ASSESSOR) Page 2 OF 3

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.
- ☐ Their right to withdraw their request at any time and in any manner.
- ☐ The recommendation to seek advice on life insurance implications.

I have determined that the patient meets the following criteria to be eligible for medical assistance in dying:
If patient is ineligible based on one or more criteria, select "Did Not Assess" for any remaining criteria that are not assessed.

☐ Yes ☐ No ☐ Did Not Assess	Is the patient eligible for health services funded by a government in Canada? *(Answer "Yes" if the patient would have been eligible but for an applicable minimum waiting period of residence or waiting period.)*
☐ Yes ☐ No ☐ Did Not Assess	Is the patient at least 18 years of age?
☐ Yes ☐ No ☐ Did Not Assess	Is the patient capable of making this health care decision?
☐ Yes ☐ No ☐ Did Not Assess	Did the patient make a voluntary request for MAiD that, in particular, was not made as a result of external pressure? **If Yes**, indicate why you are of this opinion (select all that apply): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAiD ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other - Specify:
☐ Yes ☐ No ☐ Did Not Assess	Did the patient give informed consent to receive MAiD after having been informed of the means that were available to relieve their suffering, including palliative care? *Palliative care is an approach that improves the quality of life of patients and their families facing life threatening illnesses, through the prevention and relief of pain and other physical symptoms, and psychological and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.*
☐ Yes ☐ No ☐ Did Not Assess	Does the patient have a serious and incurable illness, disease or disability? If Yes, indicate the illness, disease or disability (select all that apply): ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other - specify below ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other (For stroke, select cardiovascular condition below) - specify below ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke) - specify below ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities - specify below ☐ Other illness, disease or disability - specify below
	Additional Information Relevant to Patient's Illness, Disease, or Disability

Medical Assistance in Dying ASSESSMENT RECORD (ASSESSOR) Page 3 OF 3

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

Eligibility criteria for medical assistance in dying continued:

☐ Yes ☐ No ☐ Did Not Assess	Is the patient in an advanced state of irreversible decline in capability?
☐ Yes ☐ No ☐ Did Not Assess	Does the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that is intolerable to them and can not be relieved under conditions that they consider acceptable? **If Yes**, indicate how the patient described their suffering (select all that apply): ☐ Loss of ability to engage in activities making life meaningful ☐ Loss of dignity ☐ Isolation or loneliness ☐ Loss of ability to perform activities of daily living (e.g., bathing, food preparation, finances) ☐ Loss of control of bodily functions ☐ Perceived burden on family, friends or caregivers ☐ Inadequate pain control, or concern about it ☐ Inadequate control of other symptoms, or concern about it ☐ Other - Specify:
☐ Yes ☐ No ☐ Did Not Assess	Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?

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

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

OR

☐ I have **reason to be concerned** about the capability of the patient to provide informed consent.

☐ I have referred the patient to another practitioner for an assessment of capability to provide informed consent.

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	Date (YYYY / MM / DD)	Time

If planning was discontinued prior to administration, indicate reason:

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

Health Authority fax numbers for submission of forms:

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

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