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MEDICAL ASSISTANCE IN DYING (MAiD) RECORD OF PATIENT REQUEST

Retain with related forms in the health record. Prescriber to submit copies to an agency tasked with completing a review of medical assistance in dying and, for health authority cases, as directed by the health authority.

A. Patient Information					
Last name	**First name**	**Middle name**	**Date of birth**	**Gender** ☐ M ☐ F ☐ Other	**PHN**
Medical diagnosis relevant to request for assisted death					
Location (site, unit) **of request**					

I, _____ , am at least 18 years of age and I request and voluntarily consent to the termination of my life.

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 understand that I will be assessed for eligibility by one or more colleagues of my physician and, if eligible, a pharmacist and other staff will be contacted to aid my physician in addressing my request.
INITIALS	I understand that my physician will confirm with me whether my request is to take prescribed medication(s) that I may self-administer (assisted suicide) or that a physician will administer medications to me (voluntary euthanasia). I understand that if I choose self-administration and the regimen is not effective within a reasonable period of time, as determined by my physician, my physician will administer intravenous medication to fulfill 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.
INITIALS	I make this request voluntarily and without pressure from others.

Patient signature for initial request

Print name: _____ **Signature:** _____ **Date:** _____

If patient is physically unable to sign, a proxy may sign on the patient's behalf and express direction.
(Cannot be the same person as the witness. 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 benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.)

Print name: _____ **Signature:** _____ **Date:** _____

Relationship: _____ **Phone:** _____

Address: _____

Print Shop # 263412

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Declaration of independent witnesses

By initialing and signing below, I declare that I am at least 18 years of age and understand the nature of the request for medical assistance in dying.

Witness 1	Witness 2	
INITIALS	INITIALS	1. The patient is personally known to me or has provided proof of identity.
INITIALS	INITIALS	2. The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence.
INITIALS	INITIALS	3. I am not 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	4. 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	5. I am not directly involved in providing health care services to the patient.
INITIALS	INITIALS	6. I do not directly provide personal care to the patient.

Witness signatures

Witness 1				
Print name	**Signature**		**Date**	
Phone #	**Address**	**City**	**Province**	**Postal code**
Witness 2				
Print name	**Signature**		**Date**	
Phone #	**Address**	**City**	**Province**	**Postal code**

Confirmation of request immediately prior to administration

I am aware that a near relative/next of kin will be advised that I have requested and received medical assistance in dying.

Name:_____ Relationship to patient: _____

Phone:_____ Address: _____

Patient signature for confirmation of request

Print name:_____ Signature:_____ Date: _____

If patient is physically unable to sign, a proxy may sign on the patient's behalf and express direction.
(Cannot be the same person as the witness. 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 benefit resulting from the death of the patient, and must sign in the presence of the patient.)

Print name:_____ Signature: _____ Date: _____

Relationship: _____

Phone:_____ Address: _____