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MEDICAL ASSISTANCE IN DYING (MAiD) RECORD OF ASSESSMENT (PRESCRIBER)

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

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					

B. Practitioner conducting assessment				
Last name	**First name**	**Middle name**	**CPSID #**	**Phone number**
Mailing address			**City**	**Postal code**

INITIALS	I have been contacted by the patient or another colleague and agree to be an assessor. I am prepared to be the prescriber concerning this patient's request for medical assistance in dying.

Confirmation of eligibility and informed consent
Each assessing physician is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below*.

Patient diagnosis:_____

Patient prognosis:_____

This assessment was conducted:

☐ In person → Date:_____

☐ By telemedicine → Give name and college ID of regulated health professional

Name:_____ College ID:_____ Date: _____

I confirm that:

INITIALS	The patient is personally known to me or has provided proof of identity.
INITIALS	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.
INITIALS	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
INITIALS	The patient's request for medical assistance in dying was signed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
INITIALS	I have satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.

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I have determined that the patient meets all of the criteria to be eligible for medical assistance in dying:

INITIALS	1. The person is eligible for health services funded by a government in Canada
INITIALS	2. The person is at least 18 years of age
INITIALS	3. The person is capable of making this health care decision
INITIALS	4. The person has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the person considers acceptable. The person is in an advanced state of irreversible decline and natural death is reasonably foreseeable.
INITIALS	5. The person has made a voluntary request for medical assistance in dying that was not made as a result of external pressure
INITIALS	6. After having been informed of the means that are available to relieve their suffering, including palliative care, the person has given informed consent to receive medical assistance in dying

I **have also determined that the patient has been fully informed of:**

- His or her medical diagnosis and prognosis
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
- His or her right to rescind the request at any time
- The potential risks associated with taking the medication to be prescribed
- The probable outcome/result of taking the medication to be prescribed
- The recommendation to seek advice on life insurance implications

Consideration of capability to provide informed consent" (Indicate one of the following):

INITIALS	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.
INITIALS	I have reason to be concerned about capability and I have referred the patient to Dr._____ for a determination of capability to provide informed consent. On receipt of the requested opinion, I determine that the patient: ☐ Is capable of providing informed consent ☐ Is **not** capable of providing informed consent

Conclusion regarding eligibility

I determine that the patient: ☐ Does meet the criteria for medical assistance in dying
☐ Does not* meet the criteria for medical assistance in dying**

Physician signature: _____ **College ID:**_____ **Date:**_____ **Time:**_____

* Comments for any matter in any section are clarified in the medical record.

** Capable means that person is able to understand the relevant information and the consequences of their choices

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

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Planning

INITIALS	I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for medical assistance in dying.
INITIALS	*I have discussed with the patient the options of routes and the patient has requested:* ☐ Self-administration (assisted suicide) or ☐ Intravenous medication administered by a physician (voluntary euthanasia)
INITIALS	*Contingency planning for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)*
INITIALS	*A location and timeline for provision* *Planned location:*_____ *Planned date:*_____ *Days from initial request:*____ *If the intended date is less than 10 days from the initial request, please indicate rationale:* _____
INITIALS	*I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 48 hours after confirmation of death.*
INITIALS	*I have indicated on the prescription or order that the medication is for medical assistance in dying*

Administration

Date:_____ Location: ☐ Home ☐ Facility (site and unit): _____

☐ Office (address): _____

INITIALS	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw his or her request and gave express informed and voluntary consent
INITIALS	The medication was administered via the method chosen by patient: ☐ Physician administered (IV) ☐ Self-administration (oral) ☐ Physician administered on determination that ____ hours after ineffective self-administration Comment:_____
INITIALS	Medication administered: _____ Interval between administration and confirmation of death:_____ Event comments Please indicate who was present, whether there were aspects that went well, any suggestions for improvement that could improve the experience for other patients and colleagues. _____ _____ _____ _____ _____