



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



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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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	
<input type="checkbox"/>	I have been contacted by the patient or another colleague and agree to be an assessor concerning this patient's request for medical assistance in dying. I am aware that, if the patient is eligible, Dr. _____ will be the prescriber.				

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:

<input type="checkbox"/>	The patient is personally known to me or has provided proof of identity.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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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DRDR106757A

New: July 26/16

Page: 2 of 2

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: <input type="checkbox"/> Is capable of providing informed consent <input type="checkbox"/> 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.