fraserhealth

BRITISH COLUMBIA | Ministry of Health

MEDICAL ASSISTANCE IN DYING
CONSULTANT'S ASSESSMENT OF PATIENT'S INFORMED CONSENT DECISION CAPABILITY

DRDR106754C (HLTH 1635) Rev: Apr 18/18 Page: 1 of 1

Consultant to fax or mail a **COPY** of this Assessment to the applicable health authority (see below). Retain original in patient's health record and provide a copy to referring practitioner. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

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

Medical Diagnosis (diagnoses that indicate a grievous and irremediable medical condition, intolerable suffering, and death as being reasonably forseeable)

REFERRING PRACTITIONER

Last Name	First Name	CPSID #	OR	CRNBC Prescriber #	Phone Number

Mailing Address	City	Postal Code

CONSULTANT PRACTITIONER

Last Name	First Name and Initial	College #	Phone Number	Fax Number

Mailing Address	City	Postal Code	Email Address

Specialty ☐ Psychiatry ☐ Geriatric Medicine ☐ Other - specify:

Location of Assessment ☐ Home ☐ Facility/Other (specify):

PROFESSIONAL INTERPRETER (PLS OR OTHER) IF USED

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

CONSULTANT PRACTITIONER ASSESSMENT AND DETERMINATION OF PATIENT'S CAPABILITY TO PROVIDE INFORMED CONSENT

Date(s) of Examinations(s)	**Document assessment process and findings in the medical record.**

Confirmation

☐ I confirm that on this/these dates, I met with the patient and informed them of the reason for this assessment, and I confirmed the patient's consent to conduct an assessment to determine their capability to consent to medical assistance in dying.

I have assessed the patient in person and have determined:

Initials	
	The patient does not have capability. A psychiatric illness/cognitive impairment is present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.

OR

Initials	
	The patient has capability. A psychiatric illness/cognitive impairment is **not** present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.

I have discussed my findings with the patient, and will advise the referring practitioner.

CONSULTANT PRACTITIONER SIGNATURE

Practitioner Signature	Date (YYYY / MM / DD)	Time

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

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855 **Northern HA**: Fax: 250-565-2640

Interior HA: Fax: 250-469-7066 **Vancouver Coastal HA:** Fax: 1-888-865-2941

Vancouver Island HA: Fax: 250-727-4335

Provincial Health Services Authority: Fax: 604-829-2631

For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1636. http://www2.gov.bc.ca/assets/gov/health/forms/1636.pdf

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