fraserhealth

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

DRDR106754A New: July 26/16 Page: 1 of 1

When this form is completed fax to 604-523-8855, retain original in the patient's chart, and contact the other providers involved to proceed with addressing the patient's request. Contact mccc@fraserhealth.ca for questions.

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. Referring practitioner

Last name	First name	CPSID #	Phone number

Mailing address	City	Postal code

C. Consultant practitioner

Last name	First name	CPSID #	Phone number

Mailing address	City	Postal code

Specialty
☐ Psychiatry ☐ Geriatric medicine ☐ Neurology ☐ Other: _____

D. Consultant evaluation

Date(s) of examination(s): _____

- Document assessment process and findings in the medical record.
- Copy of chart documentation to be submitted to coroner and health authority review contact along with forms.

Confirmation

☐ INITIALS I confirm that on this/these date(s), I met with the patient, informed him/her of the reason for this assessment, and confirmed his/her consent to conduct an assessment to determine capability to consent to medical assistance in dying.

I have assessed the patient in person and have determined:

☐ INITIALS A psychiatric illness/cognitive impairment **is** present to a degree that impairs ability to make an informed consent decision regarding assisted death. **The patient does not have capability.**

or

☐ INITIALS A psychiatric illness/cognitive impairment **is not** present to a degree that impairs ability to make an informed Initials consent decision regarding assisted death. **The patient has capability.**

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

Physician's signature: _____ **Date:** _____

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