



# MEDICAL ASSISTANCE IN DYING PATIENT REQUEST RECORD



CWXX106758D (HLTH 1632)

Rev: Oct 29/18

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**▶ Patient: submit this form to your doctor or nurse practitioner, or MAiD Care Coordination Service.  
Practitioner: if required, fax or mail a **COPY** of this form to the applicable health authority MAiD CCS.  
See page 2 for MAiD Care Coordination service contact information.**

## PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN) <input type="checkbox"/> N/A		Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:	
Patient's Home / Residence Address			Postal Code		Phone Number
Medical Diagnosis Relevant to Request for Medical Assistance in Dying					
Location at Time of Request <input type="checkbox"/> Home <input type="checkbox"/> Facility/Other (specify):			Primary Health Care Provider		Phone Number

## PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

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

**By initialing and signing below, I confirm that:**

<b>Initials</b>	I am at least 18 years of age and I request medical assistance in dying. I make this request voluntarily and without pressure from others.
<b>Initials</b>	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.
<b>Initials</b>	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.
<b>Initials</b>	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.
<b>Initials</b>	I consent to be assessed for eligibility and capability by a medical or nurse practitioner(s) and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.
<b>Initials</b>	I understand that my information will be shared with other health professionals involved in my care and as required by law.
<b>Initials</b>	I have had an opportunity to ask questions and request information, and I understand that I may continue to ask questions and seek additional information.
<b>Initials</b>	I expect to die when the medication to be prescribed is administered.
<b>Initials</b>	I understand that I have the right to change my mind at any time.

## PATIENT SIGNATURE FOR INITIAL REQUEST (must be signed in front of the two independent witnesses listed on page 2)

Signature of Patient		Print Name		Date Signed (YYYY / MM / DD)	
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## PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the patient and the two independent witnesses listed on page 2)

**If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction.** The proxy cannot be either of the witnesses listed on page 2 of this request form. The proxy 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 material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.

Signature of Proxy		Print Name		Relationship to Patient		
		Date Signed (YYYY / MM / DD)		Phone Number		
Address			City		Province	Postal Code

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## CONFIRMATION OF INDEPENDENT WITNESSES

By initialing and signing below, I confirm that.

Witness 1	Witness 2	
Initials	Initials	I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
Initials	Initials	The patient is personally known to me or has provided proof of identity.
Initials	Initials	The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other witness.
Initials	Initials	I do not know or believe that I am 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	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	I am not directly involved in providing health care services to the patient.
Initials	Initials	I do not directly provide personal care to the patient.

## SIGNATURE OF INDEPENDENT WITNESSES (must be signed in the presence of the patient and the other witness)

WITNESS 1			
Signature of Witness 1	Print Name	Relationship to Patient	
	Date Signed ( YYYY / MM / DD )	Phone Number	
Address	City	Province	Postal Code

WITNESS 2			
Signature of Witness 2	Print Name	Relationship to Patient	
	Date Signed ( YYYY / MM / DD )	Phone Number	
Address	City	Province	Postal Code

## PREFERRED CONTACT FOR PATIENT

Name of Preferred Contact	Relationship to Patient	Phone Number
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**The Patient Request Record is now complete. Submit this form to your physician or nurse practitioner, or you can contact your health authority's care coordination service for medical assistance in dying (contact information below).**

**Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:**  
 For mailing addresses of Health Authorities, see:  
<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms>

<b>Fraser Health Authority</b> Phone: 604-587-7878 Fax: 604-523-8855	<b>Northern Health Authority</b> Phone: 250-645-6417 Fax: 250-565-2640	<b>Vancouver Island Health Authority</b> Phone: 1-877-370-8699 Fax: 250-727-4335
<b>Interior Health Authority</b> Phone: 1-844-469-7073 Fax: 250-469-7066	<b>Vancouver Coastal Health Authority</b> Phone: 1-844-550-5556 Fax: 1-888-865-2941	<b>Provincial Health Services Authority</b> Phone: 1-888-875-3256 Fax: 604-829-2631