



MEDICAL ASSISTANCE IN DYING ASSESSMENT RECORD (PRESCRIBER)



DRDR106755B

Rev: Dec. 15/16

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For cases involving a health authority (HA), fax or mail a copy of this Assessment to applicable HA (pg 2). Retain original in patient's health record. 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:		

Medical Diagnosis Relevant to Request for Assisted Death

PRACTITIONER CONDUCTING ASSESSMENT

Last Name		First Name		Second Name	
CPSID #	OR	CRNBC Prescriber #	Phone Number		
Mailing Address				City	Postal Code
Location of Assessment <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:					

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 dying.

CONFIRMATION OF ELIGIBILITY AND INFORMED CONSENT

Each assessing medical or nurse practitioner (practitioner) is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below. *Comments for any matter in any section are clarified in the medical record.*
 If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of their option to seek another opinion.

Patient Diagnosis
Patient Prognosis

Assessment Was Conducted

<input type="checkbox"/> In Person	Date of Assessment				
<input type="checkbox"/> By Telemedicine	Date of Assessment	Name of Witness - Regulated Health Professional	Profession	College ID	

By initialing and signing, I confirm that:

Initials	The patient is personally known to me or has provided proof of identity, and has consented to this assessment.
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	I am 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.
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	The other assessor and I are not each other's mentor or supervisor, and I do not know or believe that I am connected to the other assessor or to the patient in any other way that would affect my objectivity.

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

- Their medical diagnosis and prognosis.
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- Their right to withdraw their request at any time and in any manner.
- 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.

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

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

Consideration of capability to provide informed consent. Initial one of the following:
(Capable means that person is able to understand the relevant information and the consequences of their choices)

Initials I have **no reason** to believe the patient is incapable of providing informed consent to medical assistance in dying.

OR

Initials	I have reason to be concerned about capability and I have referred the patient to another practitioner for an assessment of capability to provide informed consent to medical assistance in dying.
	Name of Practitioner Performing Determination of Capability
	On receipt of the requested assessment, 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 and PRACTITIONER SIGNATURE

I determine that the patient:
 Does meet the criteria for medical assistance in dying Does **not** meet the criteria for medical assistance in dying
If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.

Practitioner Signature	CPSID #	OR	CRNBC Prescriber #
	Date		Time

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

