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BRITISH COLUMBIA | Ministry of Health

MEDICAL ASSISTANCE IN DYING ASSESSMENT RECORD (ASSESSOR)

DRDR106757C (HLTH 1633) Rev: Apr 18/18

Assessor is to fax or mail a **COPY** of this Assessment to the applicable health authority (see 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
		☐ Male ☐ Female ☐ Other - specify:

PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name

☐ CPSID # ☐ CRNBC Prescriber #	Phone Number	Fax Number	Email Address

Mailing Address	City	Postal Code

PROFESSIONAL INTERPRETER (PLS OR OTHER) IF USED

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

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 the patient is determined to not meet the criteria, the practitioner assessor is to advise attending practitioner and patient of determination and of his or her option to seek another opinion.

Assessment Date (YYYY / MM / DD)	☐ In Person ☐ By Telemedicine	If Telemedicine:Name of Witness (Regulated Health Professional)	Witness Profession	Witness College ID

Location of Assessment

☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:

Patient Diagnosis (diagnoses that indicate a grievous and irremediable medical condition, intolerable suffering, and natural death has become reasonably foreseeable)

Patient Prognosis (estimated time to death, based on your professional opinion)

☐ < 1 month ☐ 1 - 3 months ☐ 4 - 6 months ☐ 7 months - 1 year ☐ > 1 year

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	The patient has given informed consent to receive medical assistance in dying, after having been informed of the means that are available to relieve their suffering, including palliative care.
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 a determination of capability to provide informed consent to medical assistance in dying.
	Name of Practitioner Performing Determination of Capability
	On receipt of the requested opinion, I determine that the patient: ☐ is capable of providing informed consent ☐ 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	Date (YYYY / MM / DD)	Time

If planning was discontinued prior to administration, indicate reason and submit this form to the appropriate Health Authority.

☐ Patient withdrew request
☐ Patient's capability deteriorated (no longer capable of providing informed consent)
☐ Death occurred prior to administration

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