Western Health

Surname: First Name:

Date of Birth: Age:

MCP Number:

Address:

Postal Code:

Telephone: (Home or Cell)

Primary Care Provider Name:

Medical Assistance In Dying (MAID) Assessment Form

Assessment Date: _____

Type of Assessment: _____

Assessment Location: _____

□ 1st Assessment □ Physician □ Nurse Practitioner

□ 2nd Assessment □ Physician □ Nurse Practitioner

Medical Diagnosis Leading to MAID Assessment:

Other Relevant Diagnoses:

MAID Eligibility Criteria	YES	NO
• Eligible to receive health services in Canada.		
• 18 years of age or older.		
• Has a grievous and irremediable medical condition, i.e. a serious, incurable illness, disease or disability, AND is in an advanced state of irreversible decline in capability.		
○ **Does the patient have a serious and incurable illness, disease or disability?** a. List diagnosis/diagnoses: _____ b. Date of diagnosis/diagnoses: _____ (YYYY/DD/MM) c. List symptoms of illness, disease, or disability: _____ d. Is the illness, disease, or disability serious and incurable?		
○ **Is the patient in an advance state of irreversible decline in capability?** a. Description of decline in capability: _____ b. Decline in capability is irreversible.		
○ **Does the patient have enduring physical or psychological suffering as a result of the above condition(s), which patient reports is intolerable and not alleviated under any conditions acceptable to the patient?** a. Nature of patient's self-report of suffering: _____ b. Treatments which the patient has attempted, including clinical and subjective impact on the above condition: _____ c. Treatments which the patient has been offered and refused, including reason for refusal (including palliative and psychiatric referrals): _____		

○ **Has the patient's natural death become reasonably foreseeable?** a. Patient's prognosis (if known): _____ b. Length of time until natural death will occur, if known: _____ c. Has the patient's natural death become reasonably foreseeable?		
• Aware of their diagnosis, prognosis, and treatment options, including the availability of Palliative Care.		
• The medical condition is causing enduring physical or psychological suffering that is intolerable and cannot be relieved in a way that is acceptable to the patient.		
• Capable of making decisions with respect to MAID.		
• Is the patient capable of understanding the information relevant to making a decision about medical assistance in dying?		
• Is the patient capable of appreciating the reasonably foreseeable consequences of giving consent to medical assistance in dying?		
• Conclusion with respect to patient's capacity to consent to Medical Assistance in Dying: ☐ CAPABLE ☐ INCAPABLE ☐ REQUIRES FURTHER ASSESSMENT		
• Is there any reason to suspect that the patient is currently incapable of consenting to any treatment related to the treatment of any health condition? If yes, explain concern.		
• Has made a verbal, voluntary request for MAID, free from coercion.		
• Has been provided with a copy of the '*Request for and Consent to Medical Assistance in Dying'* form.		
• Has signed and dated the *'Request for and Consent to Medical Assistance in Dying'* form, including the signature of one independent witness. Date:		
• Has been fully informed of their right to rescind their request for MAID at any time.		
• A *specialist consultation* is required to assist in determining capacity / eligibility (if yes, please provide details on page 3).		
• A natural death **IS** reasonably foreseeable.		
• If a natural death **IS NOT** reasonably foreseeable, and the person is not at risk of losing capacity, the start date of 90-day waiting period is: _____ (YYY/DD/MM).		
• If either assessor is of the opinion that the person is at risk of losing capacity, both assessors will agree upon a course of action and inform the MAID Care Coordination Office.		

Physician/Nurse Practitioner Declaration – Patient is Eligible for MAID

I have determined that the above-named patient **meets the eligibility criteria** for MAID**.**

_____ _____ _____

Physician/Nurse Practitioner (Print) Signature of Physician/Nurse Practitioner License #

Date: _____ (YYYY/DD/MM)

Physician/Nurse Practitioner Declaration – Patient is Ineligible for MAID

I have determined that the above-named patient **does not meet the eligibility criteria** for MAID.

_____ _____ _____

Physician/Nurse Practitioner (Print) Signature of Physician/Nurse Practitioner License #

Date: _____ (YYYY/DD/MM)

I confirm that this clinical encounter must be documented in the patient's health record. _____ (please initial)

Medical Assistance In Dying (MAID) Assessment Form

Eligibility for Medical Assistance in Dying

Patient Name: _____

Date of Birth: _____

MCP: _____

Is the patient eligible for Medical Assistance in Dying? ☐ YES ☐ NO

II. Attestation (To be completed following second opinion.)

I hereby declare and affirm the following (check all that apply):

- ☐ The patient is personally known to me or has provided proof of identity.
- ☐ I have no knowledge or belief that I am or will be a beneficiary under the will of the patient making the request for medical assistance in dying.
- ☐ I have no knowledge or belief that I am or will be recipient of a financial or other benefit resulting from the person's request for Medical Assistance in Dying (other than standard compensation through MCP billing).
- ☐ I am not connected to the patient requesting MAID that would in any way impact upon my objectivity in providing this assessment.
- ☐ I am not a mentor, nor am I mentored, by the physician who provided the second opinion with respect to this patient's request for MAID.
- ☐ I do not supervise, nor am I supervised, by the physician who provided the second opinion with respect to this patient's request for MAID (*with exception of Clinical Chiefs and division heads who can provide first or second opinion with a colleague within their division).
- ☐ I am not connected with the physician who provided the second opinion with respect to this patient's request for MAID in a manner that would affect my objectivity in providing this assessment.

Name: _____, MD Signature: _____, MD

Date: _____ (YYYY/DD/MM)

I confirm that this clinical encounter must be documented in the patient's health record. _____ (please initial)