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POLICY TITLE **Medical Assistance in Dying (MAiD)** **INTERIM Policy & Procedure DRAFT #6 June 29, 2016**		**NUMBER** TBA
AUTHORIZATION VP, Community Hospitals & Programs VP, Medicine VP, Regional Hospitals & Communties	**DATE APPROVED** (No Bold Month Year)	**CURRENT VERSION DATE** (No Bold Month Year)

DATE(S) REVISED / REVIEWED SUMMARY

Version	Date	Comments / Changes
1.0	Month Year	Initial Policy Released
2.0	Month Year	
3.0	Month Year	

INTENT / PURPOSE

This policy and procedure sets out the expectations and standards of care for Fraser Health **Staff**[1] in sensitively addressing a person's request for **Medical Assistance in Dying (MAiD)** and is applicable to all Fraser Health services, owned and operated, contracted and affiliated settings.

POLICY

1.1. **Fraser Health supports requests for Medical Assistance in Dying for a person if they meet the following criteria as set out in the Amendments to the Criminal Code presented as Bill C-14:**

(a) They are eligible for health services funded by a government in Canada
(b) They are at least 19 years of age and capable of making decision with respect to their health
(c) They have a grievous and irremediable medical condition
(d) They have made a voluntary request for Medical Assistance in Dying that was not made as result of external pressure
(e) They give 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.

Fraser Health Staff in owned and operated and contracted settings sensitively address a person's request for information about Medical Assistance in Dying, and engage or make an **Effective Transfer of Care** to colleagues to consider and, if appropriate, fulfil that request.

1 See Glossary section for those terms highlighted in bold

2 Adapted from Canadian Medical Association, (2016). Principles-based Recommendations for a Canadian Approach to Assisted Dying. Ottawa

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1.2. Grievous and Irremediable Medical Condition

A person has a grievous and irremediable medical condition if he/she meets the following criteria:

(a) They have a serious and incurable illness, disease or disability
(b) They are in an advanced state of irreversible decline in capability
(c) That illness, disease or disability or that state of decline causes them enduring physical and psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable
(d) Their natural death has become reasonable foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

1.3. Safeguards

Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must:

(a) be of the opinion that the person meets all of the criteria set out in Bill C-14 subsection (1)

(b) ensure that the person's request for medical assistance in dying was
(i) made in writing and signed and dated by the person or by another person and
(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition

(c) be satisfied that the request was signed and dated by the person — or by another person as per Bill C-14, subsection (4) — before two independent witnesses who then also signed and dated the request

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in Bill

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C-14 subsection (1)

(e) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

(i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

1.4. Capability

Consent to medically assisted death will be obtained consistent with the BC Health Care Consent and Care Facilities Admission Act.

Elements of consent:

An adult consents to healthcare if:

(a) The consent relates to the proposed health care

(b) The consent is given voluntarily

(c) The consent is not obtained by fraud or misrepresentation

(d) The adult is capable of making a decision about whether to give or refuse consent to the proposed health care

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(e) The health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about :

(i) The condition for which the health care is proposed

(ii) The nature of the proposed health care

(iii) The risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

(iv) Alternative courses of health care, and

(v) The adult has an opportunity to ask questions and receive answers about the proposed health care

1.5 Incapability

When deciding whether an adult is incapable of giving, refusing, or revoking consent to health care, a health care provider must base the decision on whether or not the adult demonstrates that he or she understands:

(a) The information given by the health care provider under section 6(e) of the BC Health Care Consent and Facilities Admission Act (section 1.4 (e) above) , and

(b) That the information applies to the situation of the adult for whom the health care is proposed.

1.6. Consent must be Confirmed Throughout

A person who has given consent to Medical Assistance in Dying may withdraw consent at any time.

1.7. Fraser Health Providers Confirm no Remediable Challenges

A request for Medical Assistance in Dying requires a careful exploration of the causes of a person's suffering, confirmation that the person is aware of all available alternatives including palliative care consultation, and consideration of any undue influence arising from psychosocial, spiritual, or non-medical conditions and circumstance.

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1.8. Service Provided at Person's Location

Service will be provided at the person's current location if in acute care, or at home, or in a Fraser Health owned and operated facility. If the person is in a contracted facility, they will be asked whether they wish a Fraser Health team to attend and provide the service or whether they wish the person to be transferred.

Every effort will be made by care teams to facilitate **Assessment** and **Provision** of Medical Assistance in Dying in the current location of choice for individual persons, including their community home, irrespective of whether the care team in that setting is involved in the Assessment and Provision.

If the person has a specific location or environmental preference Fraser Health will make every effort to accommodate that request.

1.9. Individual Conscientious Objection Respected for Care Directly Related to Medical Assistance in Dying

Fraser Health respects individual health care providers in their **Conscientious Objection** to serving as one of the providers conducting an Assessment for Medical Assistance in Dying or to participating in the preparation or direct administration of the medication for Provision of Medical Assistance in Dying.
All Staff continue to provide care other than that directly related to Medical Assistance in Dying.

1.10. Staff Act in Good Faith

Staff act in good faith, do not discriminate against a person requesting assistance in dying, do not delay, impede or block access to a request for assistance in dying, and continue to provide care other than that directly related to Medical Assistance in Dying[2].

1.11. Potential acknowledged for Conscientious Objection by faith-based organizations. Fraser Health respects that faith-based Organizations may decide to not perform or allow Assessment for or Provision of Medical

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Assistance in Dying on organization property but expects that these non-participating organizations:

a) ensure the person has full information of services available to them other than Medical Assistance in Dying which may address the person's concern;
b) make capable persons aware of available information resources (Effective Transfer of Care);
c) respect and do not impede the person's request for information concerning Medical Assistance in Dying (i.e. make an Effective Transfer of Care); and
d) continue to provide comprehensive care for the person other than Assessment for or Provision of Medical Assistance in Dying, including care for the person during the period of reflection before Provision of Medical Assistance in Dying.

1.12. Monitoring, Oversight and Quality Review

Health care providers involved in the Assessment and Provision of Medical Assistance in Dying will complete and submit for review the documentation required by Fraser Health and external agencies within the specified timelines, details of which will be revised from time to time.

The Fraser Health Medical Assistance in Dying (MAiD) Care Coordination Centre (MCCC) will coordinate and provide oversight to requests as per Appendix G. The MCCC will establish centralized processes to review reports from the Site Lead and the Medical Assistance in Dying Practitioner Provider. The MCCC will report any quality improvement opportunities to the site based Quality Committee, lead by the Site Medical Director, with a view to quality, monitoring, and system improvement. The Quality Review Process, including specified timelines, is outlined in Appendix G.

1.13. Roles and Responsibilities

1.13.1. All Staff (including Physicians and Nurse Practitioners)

Consider personal views including **Conscientious Objection** and make supervisor aware to enable development of plans to support persons while respecting Staff concerns.

Make no public comment about the site or setting of any particular person requesting or receiving Medical Assistance in Dying.

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Maintain strict confidentiality concerning a request for Medical Assistance in Dying and any other aspect of a person's personal information.

1.13.2. Direct Care Staff

Respond to persons requests for information on Medical Assistance in Dying with Fraser Health information resources: (http://www.fraserhealth.ca/health-info/health-topics/end-of-life/medical-assistance-in-dying/medical-assistance-in-dying) and immediately alert the Most Responsible Physician or Nurse Practitioner of the request.

Ensure compliance with the law and the guidance and standards of their professional regulatory body.

Physicians	www.cpsbc.ca
Nurse Practitioners	www.crnbc.ca
Registered Nurses	www.crnbc.ca
Pharmacists	www.bcpharmacists.org
Social Workers	www.bccollegeofsocialworkers.ca

1.13.3. Operations Leadership – Supervisor / Manager / Director / ED / VP / CEO

Ensure all Staff are aware of this policy.

Consider personal views and Conscientious Objection of Staff and develop plans to support persons while respecting Staff concerns.

Consider the impact of cases of Medical Assistance in Dying on care teams and provide support to Staff as may be appropriate.

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1.13.4. Most Responsible Practitioner

Ensure compliance with Bill C-14 and the Professional Standards and Guidelines concerning Medical Assistance in Dying as published by the practitioner's regulatory body.

Ensure that persons requesting Medical Assistance in Dying have had the opportunity to consider all alternative services which may alleviate their suffering.

If a Conscientious Objector, provide an Effective Transfer of Care so that person can make contact with an Assessor and Prescriber.

If not a Conscientious Objector, the Most Responsible Practitioner or Most Responsible Nurse Practitioner serves to coordinate the Assessments and engagement of the necessary Assessor(s) and Prescriber and completes all documentation concerning Medical Assistance in Dying within a twelve (12) hour timeframe.

Note: At this time, June 29, 2016, the role of Nurse Practitioners is limited in the provision of Medical Assistance in Dying. Nurse Practitioners may not determine eligibility for or provide Medical Assistance in Dying until these activities are authorized by the College of Registered Nurses of BC.

1.13.5. Assessor #1 and #2, Medical Assistance in Dying (one may be Most Responsible Physician or Nurse Practitioner)

Provide Assessment and consultative services consistent with her/his privileges assigned by Fraser Health.

Ensure that persons requesting Medical Assistance in Dying have had the opportunity to consider all alternative services which may alleviate their suffering.

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Complete Assessments and documentation required by Fraser Health and by law concerning Medical Assistance in Dying within the specified timeframes.

1.13.6. **Prescriber, Medical Assistance in Dying (may be Most Responsible Physician, Nurse Practitioner or an Assessor)**

Provide Medical Assistance in Dying only if granted privileges by Fraser Health.

Ensure that persons requesting Medical Assistance in Dying have had the opportunity to consider all alternative services which may alleviate their suffering and meet the other eligibility criteria.

Complete Assessments and documentation required by Fraser Health and by law concerning Medical Assistance in Dying.

1.13.7 **Re-Assessment**

If declined the MAiD procedure by one practitioner or nurse practitioner assessor, a waiting period of sixty (60) days must be observed before another practitioner may begin the assessment and approval process again.

The Medical Assistance in Dying Care Coordination Centre will be required to obtain the first refusing practitioner's documentation on the case and consider it prior to the provision of any service.

1.14. **Compliance**

Staff who are concerned that any element of this policy is not being followed report the issue to Medical Assistance in Dying Care Coordination Centre for follow-up at mccc@fraserhealth.ca

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GLOSSARY

Assisted Suicide (Person-Administered): involves a physician or nurse practitioner prescribing and providing the means for a capable adult person to self-administer a lethal dose of drug(s), at the request and with the consent of the person.

Conscientious Objection: objection on grounds of freedom of thought, conscience, and/or religion.

Conscientious Objector: individual who claims the right to refuse to perform assessment for, or provision of, medical assistance in dying on the grounds of freedom of thought, conscience, and/or religion.

Effective Transfer of Care[3]: an effective transfer of care would include advising persons that other physicians or nurse practitioners may be available to assist in this process or assume responsibility for their care, suggesting the person visit an alternate practitioner, or service and, if authorized by the person, transferring the medical records as required.

Faith-based Organization: an organization which declares itself in its constitution as being an organization based on religion, spirituality, or culture.

Medical Assistance in Dying: the situation in which a physician or nurse practitioner, in compliance with legislative, judicial, regulatory and organizational requirements, provides to or administers into a competent adult person a lethal dose of drug(s) that intentionally brings about the person's death, at the request and consent of the person. Medical assistance in dying includes assisted suicide and voluntary euthanasia.

Medical Assistance in Dying – Assessment (by an Assessor): the formal assessment of the person to consider whether the criteria for eligibility are met.

Medical Assistance in Dying – Provision (by a Prescriber): the prescribing and providing the means for a capable adult person to self-administer a lethal dose of drugs (assisted suicide) or the ordering and administration of a lethal dose of drugs (voluntary euthanasia) to a capable adult person.

Medical Assistance in Dying - Related Care: includes assessment consultation, provision, the preparation of the pharmaceutical regimen (pharmacist and pharmacy

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technician), or of the care directly related to administer medical assistance in dying (e.g. nurse initiation of an IV specifically for provision).

Most Responsible Practitioner / Nurse Practitioner (MRP or MRNP): the physician or nurse practitioner on record as responsible for the person's care.

Non-participating: refusal to participate in Assessment or Provision of Medical Assistance in Dying on the basis of conscientious objection.

Practitioner: a health care professional identified in the Criminal Code Amendment as entitled to provide Medical Assistance in Dying (MAiD) services and authorized to do so by their regulatory body in BC.

Staff: all employees (including management and leadership), medical staff (including physicians, nurse practitioners, midwives, dentists and nurses), residents, fellows and trainees, health care professionals, students, volunteers, contractors, researchers and other service providers engaged by Fraser Health.

Voluntary Euthanasia: involves a physician or nurse practitioner administering a lethal dose of drug(s) intended to cause the death of a capable adult person who has voluntarily requested and consented to this treatment.

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PROCEDURE

Appendices

A – Procedure

B – Record of Person Request

C - Assessor Assessment Record

D - Assessor / Prescriber Assessment Record

E - Booking Request Form

F – Informed Consent Decision Capability

G - Monitoring, Oversight & Quality Review Process

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REFERENCES

Bill C-14
http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014

BC Health Care Consent and Care Facilities Admission Act
http://www.bclaws.ca/civix/document/id/complete/statreg/96181_01

Resources	
Note: for FRASER HEALTH staff and physicians only	**General Public**
1. Fraser Health MAiD Care Coordination Centre email: mccc@fraserhealth.ca 2. Phone: Set up a special MAiD line?? Or?	1. Physician 2. http://www.fraserhealth.ca/health-info/health-topics/end-of-life/medical-assistance-in-dying/medical-assistance-in-dying

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Appendix "A"

Medical Assistance In Dying (MAID)

DRAFT
June 29, 2016

Patient and physician discuss end-of-life decisions

Attending Physician informs patient of diagnosis, prognosis, and all therapeutic possibilities; including palliative care and MAID if appropriate

Patient opts for care that does not include MAID

Patient makes initial verbal request for MAID

Patient meets criteria for MAID, including capability

Patient requests information regarding Medical Assistance in Dying that Practitioner is unwilling/unable to provide

Transfer care to another Practitioner or direct patient to contact Fraser Health at mccc@fraserhealth.ca

Patient initiates formal MAID request by filling out "*Record of Request of Patient for Medical Assistance in Dying*"

Practitioner is willing to be an Assessor or Assessor/ Prescriber (both an Assessor and Assessor/Prescriber are required)

Yes

No

Refer to willing Practitioner or contact mccc@fraserhealth.ca

Willing to be an Assessor

Willing to be an Assessor/Prescriber

Patient is capable of providing informed consent?

No

Uncertain

Refer patient to Consultant using "*Assessment by Consultant Concerning Capability to Make an Informed Consent Decision*"

Yes

Patient is capable?

No

Complete "*Record of Assessment by Assessor*" (#1)

AND

Complete "*Record of Assessment by Assessor/Prescriber*" (#2)

Revert to non-MAID end of life care

Assessor/Prescriber receives completed records from other Assessor (#1)

10 day wait from the time the request is signed by the patient unless both Assessor and Assessor/Prescriber agree to shorten the wait time

Provider discusses fully with patient self administered oral medication or Practitioner administered IV medication

Oral Medication
(patient will require an IV insertion)

IV Medication

Prescriber completes "*Clinical Order Set*" and receives medication from pharmacy in person

Prescriber completes "*Clinical Order Set*" and receives medication from pharmacy in person

Provide patient opportunity to rescind request

Provide patient opportunity to rescind request

Patient or designated proxy completes "*Confirmation of Request*"

Patient or designated proxy completes "*Confirmation of Request*"

Supervise consumption and remain with patient until death occurs

If oral medication fails within a reasonable period of time, administer IV medication and remain with patient until death

Administer medication and remain with patient until death occurs

Complete *Medical Certificate of Death*

- Record "MAID" by ticking appropriate box in "*Manner of Death*" section (new form) OR
- Record "MAID" in Part 1a *Immediate Cause of Death* (old form)

Complete Assessor/Prescriber record

Send the following documents to the Coroner
(phone call not required):

1) *Medical Certificate of Death*
2) *Record of Request of Patient for Medical Assistance in Dying*
3) *Record of Assessment by Assessor*
4) *Record of Assessment by Assessor/Prescriber*
5) *Record of Assessment* by a Consultant (if completed)

Retain copy of Documents on Patient File

Send a copy of the following documents to mccc@fraserhealth.ca or Fax: **604.523.8875** for QI purposes:
1) *Record of Request of Patient for Medical Assistance in Dying*
2) *Record of Assessment by Assessor*
3) *Record of Assessment by Assessor/Prescriber*)
4) Record of Assessment by a Consultant (if completed)

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APPENDIX "B"

Medical Assistance in Dying
Record of Patient Request

 PATIENT LABEL

Retain with related forms in the health record. Prescriber to submit copies to an agency tasked with completing a review of medical assistance in dying and, for health authority cases, as directed by the health authority.

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					
Location (site, unit) **of request**					

I, _____, am at least 19 years of age and I request and voluntarily consent to the termination of my life.

Initials	I believe that my medical condition is grievous and irremediable, my suffering is intolerable, and there are no treatments that I consider acceptable.
Initials	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.
Initials	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.
Initials	I understand that I will be assessed for eligibility by one or more colleagues of my physician and, if eligible, a pharmacist and other staff will be contacted to aid my physician in addressing my request.
Initials	I understand that my physician will confirm with me whether my request is to take prescribed medication(s) that I may self-administer (assisted suicide) or that a physician will administer medications to me (voluntary euthanasia). I understand that if I choose self-administration and the regimen is not effective within a reasonable period of time, as determined by my physician, my physician will administer intravenous medication to fulfil my request.
Initials	I have had an opportunity to ask questions and to request additional information, and have received answers to any questions and responses to any requests.
Initials	I understand that I have the right to change my mind at any time.
Initials	I expect to die when the medication to be prescribed is administered.
Initials	I make this request voluntarily and without pressure from others.

Patient signature for initial request

Print name: _____ **Signature:** _____ **Date:** _____

Proxy if patient is physically unable to sign
(Cannot be same person as witness. Must be at least 19 years old, must understand the nature of the request for medical assistance in dying and must sign in the presence of the patient and witnesses.)

Print name: _____ **Signature:** _____ **Date:** _____

Relationship: _____ **Phone:** _____

Address: _____

Medical Assistance in Dying
Record of Patient Request

PATIENT LABEL

Declaration of independent witnesses

By initialing and signing below, I declare that I am at least 19 years of age and understand the nature of the request for medical assistance in dying.

Witness 1	Witness 2	
Initials	Initials	1. The patient is personally known to me or has provided proof of identity.
Initials	Initials	2. The patient (or the proxy in the presence of the patient) signed this request in my presence.
Initials	Initials	3. I am not 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	4. 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	5. I am not directly involved in providing health care services to the patient.
Initials	Initials	6. I do not directly provide personal care to the patient.

Witness signatures

Witness 1				
Print name	**Signature**		**Date**	
Phone #	**Address**	**City**	**Province**	**Postal code**
Witness 2				
Print name	**Signature**		**Date**	
Phone #	**Address**	**City**	**Province**	**Postal code**

Confirmation of request immediately prior to administration

I am aware that a near relative/next of kin will be advised that I have requested and received medical assistance in dying.

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Patient signature for confirmation of request

Print name: _____ Signature: _____ Date: _____

Proxy if patient is physically unable to sign

(Cannot be same person as witness. Must be at least 19 years old, must understand the nature of the request for medical assistance in dying and must sign in the presence of the patient and witnesses.)

Print name: _____ Signature: _____ Date: _____

Relationship: _____

Phone: _____ Address: _____

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Appendix C

Medical Assistance in Dying
Assessor's Assessment Record

PATIENT LABEL

Retain with related forms in the health record. Prescriber to submit copies to an agency tasked with completing a review of medical assistance in dying and, for health authority cases, as directed by the health authority.

A. Patient information

Last name	First name	Middle name	Date of birth	Gender	PHN
				☐ M ☐ F ☐ Other	

Medical diagnosis relevant to request for assisted death

B. Practitioner conducting assessment

Last name	First name	Middle name	CPSID #	Phone number

Mailing address	City	Postal code

Initials — I have been contacted by the patient or another colleague and agree to be an assessor concerning this patient's request for medical assistance in dying. I am aware that, if the patient is eligible, Dr._____ will be the prescriber.

Confirmation of eligibility and informed consent

Each assessing physician is to make these determinations independently on separate forms, indicating agreement by initialing the boxes*.

Patient diagnosis: _____

Patient prognosis: _____

This assessment was conducted: ☐ In person ☐ By telemedicine Date: _____

I confirm:

Initials	The patient is personally known to me or has provided proof of identity.
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.

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

Initials	1. The person is eligible for health services funded by a government in Canada
Initials	2. The person is at least 19 years of age
Initials	3. The person is capable of making this health care decision
Initials	4. The person has a grievous and irremediable condition (illness, disease or disability) that causes the person enduring suffering that is intolerable to them and that cannot be relieved in a manner that the person considers acceptable
Initials	5. The person has made a voluntary request for medical assistance in dying that was not made as a result of external pressure
Initials	6. The person has given informed consent to receive medical assistance in dying

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

- His or her medical diagnosis and prognosis
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
- His or her right to rescind the request at any time
- 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

Consideration of capability to provide informed consent* (Indicate one of the following):**

Initials	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.
Initials	The request for medical assistance in dying is arising solely from a psychiatric condition and/or I otherwise have reason to be concerned about capability and I have referred the patient to Dr. _____ for a determination of capability to provide informed consent. 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

I determine that the patient: ☐ Does meet the criteria for medical assistance in dying
☐ Does not** meet the criteria for medical assistance in dying**

Physician signature: _____ **College ID:** _____ **Date:** _____ **Time:** _____

* Comments for any matter in any section are clarified in the medical record.
** The criteria may be revised should legislation be brought into force.
*** Capable means that person is able to understand the relevant information and the consequences of their choices
****If the patient is determined to not meet the criteria, the physician assessor is to advise attending physician and patient of determination and of his or her option to seek another opinion.

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Appendix D

Medical Assistance in Dying
Assessor/Prescriber Assessment Record

PATIENT LABEL

Retain with related forms in the health record. Prescriber to submit copies to an agency tasked with completing a review of medical assistance in dying and, for health authority cases, as directed by the health authority.

A. Patient information

Last name	First name	Middle name	Date of birth	Gender	PHN
				☐M ☐F ☐Other	

Medical diagnosis relevant to request for assisted death

B. Practitioner conducting assessment

Last name	First name	Middle name	CPSID #	Phone number

Mailing address	City	Postal code

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 in dying.

Confirmation of eligibility and informed consent

Each assessing physician is to make these determinations independently on separate forms, indicating agreement by initialing the boxes*.

Patient diagnosis: _____

Patient prognosis: _____

This assessment was conducted: ☐ In person ☐ By telemedicine Date: _____

I confirm:

Initials ____ The patient is personally known to me or has provided proof of identity.

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.

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

Initials ____ 1. The person is eligible for health services funded by a government in Canada

Initials ____ 2. The person is at least 19 years of age

Initials ____ 3. The person is capable of making this health care decision

Initials ____ 4. The person has a grievous and irremediable condition (illness, disease or disability) that causes the person enduring suffering that is intolerable to them and that cannot be relieved in a manner that the person considers acceptable

Initials ____ 5. The person has made a voluntary request for medical assistance in dying that was not made as a result of external pressure

Initials ____ 6. The person has given informed consent to receive medical assistance in dying

 PATIENT LABEL

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

- His or her medical diagnosis and prognosis
- The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
- His or her right to rescind the request at any time
- 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

Consideration of capability to provide informed consent*** (Indicate one of the following)*:*

Initials	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.
Initials	The request for medical assistance in dying is arising solely from a psychiatric condition and/or I otherwise have reason to be concerned about capability and I have referred the patient to Dr. _____ for a determination of capability to provide informed consent. 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

I determine that the patient: ☐ **Does meet the criteria for medical assistance in dying**
☐ **Does not****** **meet the criteria for medical assistance in dying**

Physician signature: _____ **College ID:** _____ **Date:** _____ **Time:** _____

* Comments for any matter in any section are clarified in the medical record.
** The criteria may be revised should legislation be brought into force.
*** Capable means that person is able to understand the relevant information and the consequences of their choices
****If the patient is determined to not meet the criteria, the physician assessor is to advise attending physician and patient of determination and of his or her option to seek another opinion.

Medical Assistance in Dying
Assessor/Prescriber Assessment Record

PATIENT LABEL

Planning

Initials	I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for medical assistance in dying.
Initials	*I have discussed with the patient the options of routes and the patient has requested:* ☐ Self-administration (assisted suicide) or or ☐ Intravenous medication administered by a physician (voluntary euthanasia)
Initials	*Contingency planning for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)*
Initials	*A location and timeline for provision* *Planned location:*_____ *Planned date:* _____ *Days from initial request:*_____ *If the intended date is is less than 10 days from the initial request, please indicate rationale:*_____
Initials	*I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 48 hours after confirmation of death.*
Initials	*I have indicated on the prescription or order that the medication is for medical assistance in dying*

Administration

Date:_____ Location: ☐ Home ☐ Facility (site and unit): _____

☐ Office (address): _____

Initials	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw his or her request and gave express informed and voluntary consent
Initials	The medication was administered via the method chosen by patient: ☐ Physician administered (IV) ☐ Self-administration (oral) ☐ Physician administered on determination that ____ hours after ineffective self-administration Comment:_____
Initials	Medication administered: _____ Interval between administration and confirmation of death: _____ Event comments Please indicate who was present, whether there were aspects that went well, any suggestions for improvement that could improve the experience for other patients and colleagues.

June 13, 2016

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MEDICAL ASSISTANCE in DYING INTERIM REQUEST FORM

Timeline
Process on receipt of request:

☐ Date Rec'd: _____

When completed fax to Home Health Service Line: 604.953.4966

Appendix "E"

DATE of REQUEST: **PERSON REQUESTING**: **PH#** :

PATIENT NAME: **PHN**: **DOB (D/M/Y)**: **GENDER:**

PRIMARY DIAGNOSIS: **SECONDARY DIAGNOSIS:**

LOCATION OF PATIENT: **CONTACT PERSON** **PH#** :

IN ORDER TO BE ELIGIBLE THE FOLLOWING MUST BE COMPLETED	COMMENTS
Approval by 2 Assessors: Yes ☐ **MAiD Care Coordination Centre (MCCC) aware? Yes** ☐ **No** ☐ ☐ **Provider Practitioner**	**Provider Name**: **Contact #**
Booking Process: (Specify as required) ☐ **Documentation Provided to MCCC** ☐ **Preferred Date:** ☐ **Time** _____ **Staff Required:** ☐ **1 Nurse** ☐ **Social Worker** **Spiritual Health Professional** ☐ ☐ **Patient Instructed to arrive by** ____ ☐ **am** _____ ☐ **pm** ☐ **Funeral Planning Done** **Yes** ☐ **No** ☐	
Family Wishes / Provides ☐ **Music** ☐ **Lighting** ☐ **Own Spiritual/Religious Provider** **Are there cultural, spiritual or religious beliefs or practices we need to be aware of in order to provide you and your family with the best possible care at the time of death?** ☐ **Yes** ☐ **No**	**Personal Choices:** **Give Details:**
Will Caregiver/Family be present? Yes ☐ **No** ☐ If so, how many? _____ **NOK present: Yes** ☐ **No** ☐	
Executor: Name: **Contact #** **Present: Yes** ☐ **No** ☐ **If no, must be available by phone at time of procedure.**	

FOR MCCC USE ONLY:

2 ASSESSOR/PROVIDER PROCESS COMPLETE **Yes** ☐ **No** ☐

Location of Service: Site _____ Unit: _____ Site Lead: _____ Phone #: _____

Pharmacy Lead Aware: **Yes** ☐ **No** ☐ Name: _____ Phone #:_____

Site Lead Contacted: **Yes** ☐ **No** ☐ Name: _____ Phone #: _____

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Appendix F

Medical Assistance in Dying
Consultant Assessment of Patient's Informed Consent Decision Capability

PATIENT LABEL

Retain with related forms in the health record. Prescriber to submit copies to an agency tasked with completing a review of medical assistance in dying and, for health authority cases, as directed by the health authority.

A. Patient information

Last name	First name	Middle name	Date of birth	Gender	PHN
				☐ M ☐ F ☐ Other	

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 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:** _____

APPENDIX G

MONITORING, OVERSIGHT & QUALITY REVIEW PROCESS