ELIGIBILITY ASSESSMENT
Medical Assistance in Dying (MAiD)

Eligibility assessment information
Assessment conducted by: ☐ 1st assessor ☐ 2nd assessor
Date of patient's written request (YYYY-MM-DD):
Date of assessment (YYYY-MM-DD):

Patient information		
First name	Middle name	Last name
Date of birth (YYYY-MM-DD)	Medicare no.	Medical record no.
Family physician / nurse practitioner (NP)	Telephone	Diagnosis Date of diagnosis (YYYY-MM-DD)
Allergies or reaction:		

Physician/NP information		
First name	Last name	☐ Physician ☐ NP
If you are a physician, what is your specialty?	Telephone	Zone

Patient eligibility criteria		
YES	**NO**	
		The patient is eligible for publicly funded health care in Canada.
		The patient is at least 18 years of age.
		The patient is capable of making decisions about their health (decision-making capacity).

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YES	NO	
		The patient submitted their MAiD request of their own free will and without external pressures. If **yes**, indicate why you are of this opinion: ☐ Consultation with the patient ☐ Knowledge of the patient from previous consultations for reasons other than MAiD ☐ Consultation with another health or social services professional ☐ Consultation with family or loved ones ☐ Review of medical record ☐ Other (please specify): ___ ___
		The patient suffers from a serious and incurable illness, disease or disability. If **yes**, please indicate the illness, disease or disability (select all that apply): ☐ Cancer – Lung and Bronchus ☐ Cancer – Breast ☐ Cancer – Colorectal ☐ Cancer – Pancreas ☐ Cancer – Prostate ☐ Cancer – Ovarian ☐ Cancer – Hematologic ☐ Cancer – Other (specify) ___ ☐ Neurological disorder – Multiple Sclerosis ☐ Neurological disorder – Amyotrophic Lateral Sclerosis ☐ Neurological disorder – Other (specify) ___ ☐ Chronic respiratory disease (e.g. chronic obstructive pulmonary disease) ☐ Cardiovascular disease (e.g. stroke, congestive heart failure) ☐ Other organ failure (e.g. end-stage renal disease) ☐ Multiple comorbidities (specify) ___ ☐ Other illness, disease or disability (specify) ___ ___
		The patient is in an advanced state of irreversible decline in capability.

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YES	NO	
		Due to their illness, disease, disability or advanced state of irreversible decline in capability, the patient is experiencing unbearable, enduring physical or psychological suffering that cannot be relieved in a manner that is acceptable to them. **For the purposes of the MAiD eligibility assessment, individuals suffering solely from mental illness are not eligible.** If **yes**, please indicate how the patient describes their suffering (select all that apply): ☐ Insufficient pain management or concerns about this ☐ Insufficient management of other symptoms or concerns about this ☐ Loss of ability to participate in meaningful activities ☐ Loss of dignity ☐ Loss of ability to perform activities of daily living (e.g. cook, shower) ☐ Loss of control of bodily functions ☐ Other (specify) ____
Foreseeability of natural death		
		The patient's natural death has become reasonably foreseeable if all medical issues are considered. **Planned date of MAiD (if determined)** (YYYY-MM-DD)**:** _________________
		If **natural death is not reasonably foreseeable**, please confirm: ☐ The patient has been informed of all means available to relieve their suffering, including psychological support services, community services and palliative care, and was referred to professionals who provide these services. ☐ You have discussed with the patient the means available to relieve their suffering and the patient has seriously considered these means. ☐ I referred the patient to professional who provide support services. **Date from which MAiD may be administered (at least 90 clear days from the first assessment)** (YYYY-MM-DD)**:** _________________

RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

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Additional information
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☐ **Patient eligible –** Declaration of physician/NP

☐ I declare that the aforementioned patient **meets** the eligibility criteria for MAiD.

☐ I conducted an independent assessment pursuant to the *Criminal Code*. Therefore, I declare that I am independent of both the patient and the second assessor.

☐ **Patient ineligible –** Declaration of the physician/NP

☐ I declare that the aforementioned patient **does not meet** the eligibility criteria for MAiD.

☐ I conducted an independent assessment pursuant to the *Criminal Code*. Therefore, I declare that I am independent of both the patient and the second assessor.

Please indicate why the patient **does not meet** the eligibility criteria for MAiD:

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____________________	____________________	____________
Name of physician/NP (please print)	Signature of physician/NP	YYYY-MM-DD

If you have any questions, please contact the Risk Management Service at amm.maid@vitalitenb.ca or the Ethics Office at ethique.ethics@vitalitenb.ca