RÉSEAU DE SANTÉ
vitalité
HEALTH NETWORK

PATIENT CONSENT
Medical Assistance in Dying (MAiD)

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

Patient declaration

I, undersigned, am suffering from an illness deemed serious and incurable. My eligibility for MAiD has been confirmed by two assessments by a physician or nurse practitioner.
I have received all necessary information about my diagnosis, my prognosis, and the range of possible treatments and various end-of-life services available to me, including palliative care, comfort care and pain management care. I understand the risks and probable consequences associated with taking the medications that will be prescribed and administered.
I also understand that if my natural death is not reasonably foreseeable, a 90-day waiting period is required following my first eligibility assessment.
I request that a physician or nurse practitioner;

❑ Prescribe and administer to me medications that will end my life with human dignity;
❑ Prescribe medications that I will be able to self-administer to end my life.

I understand that I have the right to cancel my request at any time.

____________________	____________________	____________
Patient's name (please print)	Patient's signature	YYYY-MM-DD
Witness's name (please print)	Witness's signature	YYYY-MM-DD

Third-party signature (Note: To be completed only if the patient is incapable of signing themselves)	
☐	I am at least 18 years of age and I understand the nature of a request for medical assistance in dying.
☐	I am not or I do not believe myself to be the beneficiary of the will of the aforementioned person and I will not receive any material or financial benefit from the death of the aforementioned person.
☐	I am signing this document in the presence and as per the instructions of the aforementioned person.

____________________	____________________	____________
Third-party's name (please print)	Third-party's signature	YYYY-MM-DD
Witness's name (please print)	Witness's signature	YYYY-MM-DD

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Determination/declaration of physician or nurse practitioner

I declare that the aforementioned patient:

YES	NO	
		Is eligible for publicly funded health care in Canada;
		Is 18 years of age or over;
		Is suffering from a serious and incurable illness that is causing unbearable suffering that cannot be relieved in a manner that is acceptable to them;
		Is in an advanced state of irreversible decline in capability and: ☐ Their natural death is reasonably foreseeable; ☐ Their natural death is not reasonably foreseeable (there will be a waiting period of at least 90 clear days between the date of the first assessment and the date of administration of MAiD if the patient's natural death is not reasonably foreseeable, unless there is a documented exception)
		Is capable of requesting medical assistance in dying;
		Has made a voluntary written request to receive medical assistance in dying;
		Has been deemed eligible to receive MAiD following two independent assessments;
		Had a consultation with a physician or nurse practitioner possessing expertise in the condition at the origin of the patient's suffering (when required);
		Has been informed of the possibility of cancelling this request at any time.
		I have spoken with the aforementioned patient and informed them about their diagnosis, their prognosis, and the range of possible treatments and various end-of-life services available to them, including palliative care, comfort care and pain management care. I have also informed the patient about the risks and probable consequences associated with taking the medications that will be prescribed and administered.

Date of first assessment (yyyy-mm-dd): ___________

Planned date of MAID (yyyy-mm-dd): ___________

Name of physician or NP (please print) ______ Signature of physician or NP ______ YYYY-MM-DD ______