NL Health
Services

Name: _____

HCN: _____

Date of Birth: _____

First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part I)

CRMS Number: _____

Patient Information:

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Gender: ☐ Male ☐ Female ☐ UN

Medical Diagnosis relevant to request for assisted death:

First Provider (Primary) Information:

Name: _____ Telephone: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Registration Number: _____

Date of Assessment (YYYY/MON/DD): _____

I have received the patient's completed Medical Assistance in Dying (MAiD) Patient Request Record (D0052DEC24): ☐ Yes ☐ No

Date Patient Request Signed (YYYY/MON/DD): _____ Date Patient Request Received (YYYY/MON/DD): _____

I. Eligibility Canada

A. The patient is eligible for medical health care services publicly funded by a government in Canada: ☐ Yes ☐ No

B. The patient is at least 18 years of age: ☐ Yes ☐ No

C. Capacity to Consent:

1. Is the patient capable of understanding the information relevant to deciding to consent, or to refusing to consent, to MAiD: ☐ Yes ☐ No

2. Is the patient capable of appreciating the reasonably foreseeable consequences of consenting to or not consenting to MAiD: ☐ Yes ☐ No

3. Conclusion with respect to patient's capacity to consent to MAiD: ☐ Capable ☐ Incapable ☐ Requires further assessment

4. Have you satisfied yourself that any factors that may impact a patient's decision-making ability, such as mental health, emotional, medical or chemical conditions, have been considered and adequately addressed: ☐ Yes ☐ No

D. Grievous and Irremediable Condition:

1. Does the patient have a serious and incurable illness, disease or disability: ☐ Yes ☐ No
Note: If Mental Illness is the only underlying diagnosis then the patient is not eligible for MAiD under current legislation.

If Yes,

a. List diagnosis/diagnoses: _____

b. Date of diagnosis/diagnoses (YYYY/MON/DD): _____

c. List symptoms of illness, disease or disability: _____

Provider's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part II)

CRMS Number:_____

D. Grievous and Irremediable Condition Continued:

2. Is the patient in an advanced state of irreversible decline in capability: ☐ Yes ☐ No If yes, describe decline in capability:

3. Does the illness, disease or disability or state of decline cause the patient to endure physical or psychological suffering which the patient reports is intolerable to them and cannot be relieved under conditions they consider acceptable: ☐ Yes ☐No

If Yes:

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 care):

4. Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances, without requiring a specific prognosis as to the length of time the person has left to live: ☐ Yes ☐ No

If Yes, patient's natural death is reasonably foreseeable, complete the following:

Describe factors attributing to your assessment that the patient's natural death is reasonably foreseeable:

Estimate length of time until natural death will occur, if possible:

Is there a reasonable concern the patient may lose capacity to consent to MAiD in the near future: ☐ Yes ☐ No

If Yes:

☐ I **have** discussed the option of waiver of final consent/ advance consent agreement with the patient

☐ I **have not** discussed the option of waiver of final consent/advance consent with the patient

Provider's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part III)

CRMS Number: _____

If No, the patient's natural death is not reasonably foreseeable, complete the following:

My assessment of this patient's eligibility for MAiD began on (YYYY/MON/DD): _____

The primary cause of the patient's suffering is:

I have expertise in the patient's area of suffering? (describe applicable responses for "YES" or "NO")

☐ **YES, and:**

☐ I informed the patient of the means available to relieve their suffering including where appropriate, counseling services, mental health and disability support services, community services and palliative care, and have offered consultations with relevant professionals services of that care;

☐ The outcome of these discussions with the patient were (describe patient's response to the means offered to alleviate their suffering)

☐ The patient has advised me that they have given serious consideration to the means to relieve their suffering.

☐ The outcome of these discussions has been shared with the patient's secondary assessor, _____
(Name of Medical Provider)

OR:

☐ **NO, and:**

☐ I have consulted the following practitioner(s), with expertise in the patient's area of suffering, to ensure all treatment options (including the services and consultations referenced above) have been identified and explored:

Medical Practitioner(s)	Area(s) of Expertise

☐ I have been made aware of the outcome of this/these consultation(s); **and**

☐ The outcome of this/these consultation(s) has been shared with the patient's secondary assessor, _____
(Name of Medical Provider)

☐ The patient has advised me, they have given serious consideration to the means to relieve their suffering.

Provider's Name: _____ Signature: _____ Initals: _____ Date (YYYY/MON/DD): _____

NL Health
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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part IV)

CRMS Number:_____

Note: If the patient's natural death is NOT reasonably foreseeable and neither of the two medical practitioners assessing the patient's eligibility for MAiD have expertise in the patient's area of suffering, discussions/consultation(s) are required to occur with a medical practitioner with expertise in the condition that lead to the patient's request for MAiD.

E. Voluntary Request for Medical Assistance in Dying (MAiD):

1. Date of written request (attach copy) (YYYY/MON/DD): _____

Check each box and **initial** each when the item is verified from the written MAiD request:

☐ Signed and dated by the patient after the patient was informed by a medical practitioner that the patient has a grievous and irremediable medical condition OR if patient is unable to sign the request, signed and dated by an eligible third person aged 18 years or greater in the patient's presence and pursuant to the patient's direction. _____

☐ Declaration of Independent Witness completed._____

☐ Patient informed they can withdraw their request at any time and in any manner prior to MAiD, without impact on the care and treatment the patient will receive._____

☐ Patient is making a voluntary decision without external pressure._____

2. Inquiries with respect to the voluntariness of the request (include patient response):

3. Is there reason to believe that the patient's request for MAiD may be unduly influenced or coerced: ☐ Yes ☐ No
If Yes, specify concern:

F. Informed Consent for Medical Assistance in Dying (MAiD)

1. MAiD interventions proposed (include route of administration, medications and location of procedure):

2. Risks, side effects and benefits of MAiD, as discussed with patient:

3. Alternatives to MAiD, as discussed with the patient, including detailed discussion of palliative care or other relevant care that is available to the patient:

4. Consequences of having and not having MAiD, as discussed with the patient:

5. Questions asked by the patient and answers provided:

6. Patient has been advised that consent for MAiD may be withdrawn in any matter, at any time prior to MAiD: ☐ Yes ☐ No

7. Patient is giving consent to receive MAiD after being informed of alternative means that are available to relieve their suffering, including palliative care: ☐ Yes ☐No

Provider's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part V)

CRMS Number:_____

Conclusion: Eligibility For Medical Assistance In Dying (MAiD)

Has the patient met all the eligible criteria in Parts A, B, C, D, E and F and is thus eligible to receive MAiD:

☐ Yes, patient has met all MAiD eligibility requirements and has a reasonably foreseeable natural death; or

☐ Yes, patient has met all MAiD eligibility requirements, has a non-reasonably foreseeable natural death and I began their assessment on (DD/MONTH/YYYY)_____ (earliest date which eligible to receive is 90 clear days after the MAiD eligibility assessment began, unless both assessors agree patient is at imminent risk of losing capacity); or

☐ No, patient has not met all MAiD eligibility criteria.

II. **Attestation by Provider (Primary)** (To be completed if the conclusion is that the patient is, eligible for MAiD)

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

☐ I am the Provider (Primary) and am of the opinion that the patient meets the eligibility criteria as concluded above.

☐ 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 MAiD.

☐ I have no knowledge or belief that I am, or will be, recipient of a financial or other material benefit resulting from the person's request for MAiD (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 have received and reviewed the assessment of (Name of medical provider) _____ which concludes that the patient is eligible for MAiD and indicates, where necessary, that the Practitioner has discussed with the patient the reasonable and available means to relieve the patient's suffering, and that they agree that the patient has given serious consideration to those means.

☐ I am not a mentor to, nor am I mentored by, the practitioner who provided the second opinion with respect to this patient's request for MAiD.

☐ I do not supervise, nor am I supervised by, the practitioner 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 to the practitioner 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.

Provider's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part VI)

CRMS Number: _____

Assessor/Prescriber Assessment Record For MAiD Planning:

☐ I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for MAiD

☐ I have discussed with the patient that the medication will be administered via the intravenous (IV) route by a practitioner (voluntary euthanasia).

☐ Contingency planning for potential issues (e.g. issues with initiation of intravenous access, etc.)

☐ A location and timeline for provision:

Planned location: _____

Planned date (YYYY/MON/DD): _____ Planned time (24 Hour Clock) (HH:MM): _____

If the patient is at risk of losing capacity prior to or on the planned date for provision, did you and the patient complete a waiver of final consent (Advance Consent Agreement): ☐ Yes ☐ No

☐ I have communicated with the pharmacist the request, assessments, plan to provide and administer medical assistance in dying, and the arrangement to return any unused medications to the pharmacy within 48 hours after confirmation of death.

☐ I have indicated on the prescription or order that the medication is for MAiD.

Assessor/Prescriber's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

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First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part VII)

CRMS Number: _____

Administration of Medical Assistance in Dying (MAiD):

Date (YYYY/MON/DD): _____ Location: ☐ Patient's home (address): _____

☐ Facility (Site and unit): _____

☐ Office (address): _____

☐ Other (specify): _____

☐ Immediately prior to administering the prescription, the patient was given an opportunity to withdraw his or her request for MAiD and gave express consent to receive MAiD.

OR

☐ The patient and I completed an Advance Consent Agreement/ Waiver of Final Consent for MAiD prior to patient losing capacity and the Advance Consent Agreement/ Waiver of Final Consent was implemented as the patient lost capacity to consent at the time of scheduled MAiD provision.

☐ The medication was administered via the intravenous (IV) route by a practitioner.
Comment:

☐ Medication administered: _____

Interval between administration and confirmation of death: _____

Comments: (indicate who was present and what occurred)

☐ Patient withdrew request

☐ Patient's capability deteriorated (no longer capable of providing informed consent and Advance Consent Agreement/Waiver of Final Consent had not been in place)

☐ Patient demonstrated, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration- (other than involuntary words, sounds or gestures made in response to contact), even where an Advance Consent Agreement/Waiver of Final Consent is in place.

☐ Death occurred prior to administration

Administer's Name:	Signature:	Initals:	Date (YYYY/MON/DD):

NL Health
Services

Name: _____

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Date of Birth: _____

First Provider (Primary) Assessment for Medical Assistance in Dying (MAiD) (Part VIII)

CRMS Number: _____

FEDERAL REPORTING REQUIREMENTS:

☐ Federal reporting completed

☐ https://canada.ca/reportingmedicalassistanceindying

☐ Reference Number: _____

Return the form along with any feedback or suggestions for process improvement to:

Eastern Zone

Fax: (709)-777-7774

Email: MAiD@easternhealth.ca

Central Zone

Fax: (709)-256-4187

Email: MAiD@centralhealth.nl.ca

Western Zone

Fax: (709)-637-5159

Email: maid@westernhealth.nl.ca

Labrador- Grenfell Zone

Fax: (709)-944-3722

Email: maid@lghealth.ca

Provider's Name: _____ Signature: _____ Initals: _____ Date (YYYY/MON/DD): _____