Central Health

Patient Label

Medical Assistance in Dying
ASSESSMENT RECORD (SECOND PRACTITIONER)

PATIENT INFORMATION

Last Name	First Name	Second Name(s)
Personal Health Number (PHN)	Birthdate (YYYY/MM/DD)	Gender ☐Male ☐Female ☐Other-specify:
Medical Diagnosis Relevant to Request for Assisted Death		

PRACTITIONER CONDUCTING ASSESSMENT

Last Name	First Name	Second Name
License #		Phone Number
Mailing Address	City	Postal Code
Location of Assessment ☐ Home ☐Facility – Site: Unit: ☐Other – specify:		
Initials	I have been contacted by the patient or another colleague and I agree to be the second Practitioner concerning this patient's request for medical assistance in dying. If the patient is eligible, the Practitioner listed here will be the first Practitioner.	First Practitioner

CONFIRMATION OF ELIGIBILITY AND INFORMED CONSENT

Each assessing Practitioner is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below. *Comments for any matter in any section are clarified in the medical record.*

If the patient is determined to not meet the criteria, the second Practitioner is to advise the first Practitioner and patient of determination and of his or her option to seek another opinion.

Patient Diagnosis

Patient Prognosis

Assessment Was Conducted

☐ In Person	Date of Assessment

By initialing and signing, I confirm that:

Initials	The patient is personally known to me or has provided proof of identity, and has consented to this assessment.
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 my services relating to this request.
Initials	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
Initials	I am satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.
Initials	The patient's request for medical assistance in dying was signed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
Initials	The other assessor and I are not each other's mentor or supervisor, and I do not know or believe that I am connected to the other assessor or to the patient in any other way that would affect my objectivity.

Last Name of Patient	First Name of Patient	Second Name(s) of Patient

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

- His or her medical diagnosis and prognosis.
- The feasible alternatives including, but not limited to palliative care and pain control.
- His or her right to withdraw their request at any time and in any manner.
- 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.

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

Initials	The patient is eligible for health services funded by a government of Canada.
Initials	The patient is at least 18 years of age.
Initials	The patient is capable of making this health care decision.
Initials	The patient has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the patient considers acceptable. The patient is in an advanced state of irreversible decline and natural death is reasonably foreseeable.
Initials	The patient has made a voluntary request for medical assistance in dying that was not made as a result of external pressure.
Initials	After having been informed of the means that are available to relieve their suffering, including palliative care, the patient has given informed consent to receive medical assistance in dying.

Consideration of capacity to provide informed consent. Initial one of the following:
(*Capacity means that person is able to understand the relevant information and the consequences of their choices)*

Initials	I have **no reason** to believe the patient does not have the capacity of providing informed consent to medical assistance in dying.
	OR
Initials	I have **reason to be concerned** about this patient's capacity and I have referred the patient to another provider for a determination of capability to provide informed consent to medical assistance in dying.
	Name of Provider Performing Determination of Capacity:
	On receipt of the requested opinion, I determine that the patient: ☐ has capacity to provide informed consent ☐ **does not** have capacity to provide informed consent

CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE

I determine that the patient:
☐ Does meet the criteria for medical assistance in dying ☐ Does **not** meet the criteria for medical assistance in dying
If it is determined that the patient does not meet the criteria, the second Practitioner is to advise the first Practitioner and the patient of the determination and of the patient's option to seek another opinion.

Practitioner Signature	License #	
	Date	Time

If planning was discontinued prior to administration, indicate reason and submit this form to the Central Health.

☐ Patient withdrew request
☐ Patient's capability deteriorated (no longer capable of providing informed consent)
☐ Death occurred prior to administration

THIS FORM DOES NO CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.

When MAiD is administered, please return a copy of this form to Central Health's Health Information and Management Department by mail (to one of the addresses below) and retain original in patient's Health Care Record.

Health Information and Management
James Paton Memorial Regional Health Centre
125 Trans Canada Highway
Gander, NL A1V 1P7

Health Information and Management
Central Newfoundland Regional Health Centre
50 Union Street
Grand Falls-Windsor, NL A2A 2E1

This form was modified from the British Columbia Ministry of Health form HLTH 1634