Central Health

Patient Label

Medical Assistance in Dying
FIRST PRACTITIONER ASSESSMENT RECORD

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 an assessor. **I am prepared to be the first practitioner** concerning this patient's request for medical assistance in dying.

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 it is determined that the patient does not meet the criteria, the first practitioner is to advise the referring practitioner and the patient of determination and of their 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 capacity 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 practitioner assessor is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.

Practitioner Signature	License #	
	Date	Time

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

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

PLANNING FOR MEDICAL ASSISTANCE IN DYING

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 Central Health standardized prescription protocol for administration of medical assistance in dying.
Initials	I have planned for potential issues (issues with initiation of intravenous access, etc.)
Initials	Location and timeline for provision.
	Planned Location: ☐ Home ☐Facility – Site: Unit: ☐ Other - specify:
	Planned Date: / Days from Initial Request:
	If intended date is less than 10 clear days from initial request, the assessor, the patient and I are in agreement that: ☐ Death is imminent, or ☐ The patient's loss of capacity to provide informed consent is imminent
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 24-48 hours after confirmation of death.
Initials	I am using the Central Health standardized prescription protocol for medical assistance in dying.

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

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

ADMINISTRATION OF MEDICAL ASSISTANCE IN DYING

Date (YYYY/MM/DD)	Location: ☐ Home ☐ Facility - Site: Unit: ☐ Other - specify:
Location Address	
Initials	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw their request and gave express informed and voluntary consent to receive medical assistance in dying (pg. 2, Patient Request Record).
Initials	The medication was administered as prescribed in the Central Health standardized prescription protocol for medical assistance in dying.
	Interval Between Administration and Confirmation of Death:

PRACTITIONER SIGNATURE

Practitioner Signature	CPSNL License #	
	Date	Time

Registration of Death
The first practitioner must complete the registration of death form as per the V*ital Statistics Act 2009*

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 1633