Combined Assessment Form/Providing Practitioner Record For Medical Assistance in Dying

Patient Name
Date of Birth *(YYYY/MM/DD)*
Personal Health Number (PHN)

This information is collected under the authority of sections 20, 21, 22(2)(d) and (g) of the Health Information Act, the Regulations for the Monitoring of Medical Assistance in Dying (Canada) and O.C. 142/2016 and O.C. 320/2016 for the purpose of confirming that the requirements of standards of practice and legislation applicable to medical assistance in dying are met and for the purposes set out in section 27(1)(g), 27(2)(a), (b), and (d) of the Health Information Act. If you have any questions about the collection of this information, please contact the Health Information Act Help Desk, Alberta Health, PO Box 1360 Station Main, Edmonton, AB, T5J 2N3 or by phone at 780-427-8089 or toll free in Alberta at 310-0000, then 780-427-8089, or by email at hiahelpdesk@gov.ab.ca.

Disclosure Statement: I understand that by participating in providing any part of medical assistance in dying, my professional information will be collected, used and disclosed to the provincial and federal Ministers of Health, or their delegates, for the purpose of monitoring medical assistance in dying.

****If you are assessing only complete: Required Information and Part A - Assessor ending on page 7.**

****If you are assessing AND providing complete: the entire document.**

Required Information

Please note: Sections are numbered as per requirements from Health Canada and therefore not all Sections will appear in each part of this form. Further, Sections may appear out of order in order to maintain document flow.

1a. Client/Patient Identifying Information

Last Name	**First Name**	**Middle Name**	
Date of Birth *(YYYY/MM/DD)*	**Gender** ☐ Male ☐ Female ☐ Other	**Personal Health Number (PHN)**	**Postal Code**

1b. Practitioner Information: *Provide your information as the Practitioner.*

Last Name	**First Name**	**Designation** ☐ MD ☐ NP
If you are a physician - what is your specialty ☐ Anesthesiology ☐ Cardiology ☐ Family Medicine ☐ General Internal Medicine ☐ Geriatric Medicine ☐ Nephrology ☐ Neurology ☐ Oncology ☐ Palliative Medicine ☐ Respiratory Medicine ☐ Other – specify: _____		**CPSA/CARNA Registration #**

Mailing Address at Primary Place of Work	**City/Town**	**Province** Alberta	**Postal Code**

Telephone Numbers	**Email Address used for work**	**Have you seen this patient for medical care other than MAiD?** ☐ Yes ☐ No

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1c. Receipt of the Written Request	
From whom did you receive the written request for MAID that triggered the obligation to provide information? ☐ Patient Directly ☐ Another practitioner ☐ Care Coordination Service ☐ Another third party – specify: _____	Date of receipt of written request for MAID? *(YYYY/MM/DD)*

Declaration of Practitioner Independence: *Please initial that you have met the criteria of an Independent Practitioner. (Per Federal Legislation – Section 6)*

Initial	Practitioner Criteria
	I am independent of the person and the referring practitioner, in that I do not know or believe that I am: • not a mentor to the other practitioner or responsible for supervising their work; • not a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or • connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

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PART A - ASSESSOR

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B. Practitioner Assessment of Eligibility: *Please choose the appropriate response for each of the mandatory eligibility criteria.*

Date of Assessment: _____

Choose Response	Mandatory Eligibility Criteria
☐ Yes ☐ No ☐ Did not assess	Was the patient eligible for health services by a funded government in Canada? Answer "Yes" if the patient would have been eligible but for an applicable minimum period of residence or waiting period.
☐ Yes ☐ No ☐ Did not assess	Was the patient at least 18 years of age?
☐ Yes ☐ No ☐ Did not assess	Was the patient capable of making decisions with respect to their health?
☐ Yes ☐ No ☐ Did not assess	Did the patient make a voluntary request for MAiD that, in particular was not made as a result of external pressure? If yes, indicate why you are of this opinion (select all that apply): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAiD ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other. Specify _____
☐ Yes ☐ No ☐ Did not assess	Did the patient give informed consent to receive MAiD after having been informed of the means that were available to relieve their suffering, including palliative care?

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☐ Yes ☐ No ☐ Did not assess	Did the patient have a serious and incurable illness, disease or disability? If yes, indicate the illness, disease or disability – (select all that apply): ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other. Specify: _____ ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other. *(For stroke, select cardiovascular condition, not neurological condition – other).* Specify: _____ ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke). Specify _____ ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities. Specify: _____ ☐ Other illness, disease or disability. Specify: _____
☐ Yes ☐ No ☐ Did not assess	Was the patient in an advanced state of irreversible decline in capability?
☐ Yes ☐ No ☐ Did not assess	Did the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that was intolerable to them and could not be relieved under conditions that they considered acceptable? If **yes**, indicate how the patient described their suffering (select all that apply): ☐ Loss of ability to engage in activities making life meaningful ☐ Loss of dignity ☐ Isolation or loneliness ☐ Loss of ability to perform activities of daily living *(e.g. bathing, food preparation, finances)* ☐ Loss of control of bodily functions ☐ Perceived burden on family, friends or caregivers ☐ Inadequate pain control, or concern about it ☐ Inadequate control of other symptoms, or concerns about it ☐ Other Specify _____ *This list is intended to support practitioners in relaying the patient's description of their suffering. It is not intended to validate or invalidate various forms of suffering in respect of eligibility for MAiD.*
☐ Yes ☐ No ☐ Did not assess	Had the patient's natural death has become reasonably foreseeable, taking into account all of their medical circumstances?

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Other Information

Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory written second assessment required by the Criminal Code): ☐ Yes ☐ No	If **yes**, indicate what type of professional you consulted (select all that apply): ☐ Nurse ☐ Oncologist ☐ Palliative care specialist ☐ Primary care provider ☐ Psychiatrist ☐ Psychologist ☐ Social worker ☐ Speech pathologist ☐ Other health care professional. Specify _____
Did the patient **receive** palliative care[1]? ☐ Yes ☐ No ☐ Do not know If **yes**, for how long? ☐ Less than 2 weeks ☐ 2 weeks to less than 1 month ☐ 1-6 months ☐ more than 6 months ☐ Do not know If **no**, to the best of your knowledge or belief, was palliative care accessible to the Patient? ☐ Yes ☐ No ☐ Do not know	Did the patient **require** disability support services[2]? ☐ Yes ☐ No ☐ Do not know If **yes**, did the patient **receive** disability support services? ☐ Yes ☐ No ☐ Do not know If **yes**, for how long? ☐ Less than 6 months ☐ 6 months to less than 1 year ☐ 1 to less than 2 years ☐ 2 years or more ☐ Do not know If **no**, to the best of your knowledge or belief, were disability support services accessible to the patient? ☐ Yes ☐ No ☐ Do not know

[1] Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of pain and other physical symptoms, and psychosocial and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.

[2] Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

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C. Supplementary Information *(Provide additional supplementary information)*

D. Approval Status

Does the person meet the mandatory eligibility criteria required to access medical assistance in dying?	**If Yes, initial below**	**If No, initial below**

If the person DOES NOT meet the mandatory eligibility criteria required to access medical assistance in dying describe the reason(s) why in the space provided:

Assessing Practitioner Signature:	**Date:**	**CPSA or CARNA Registration #:**

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E. Additional Assessments Required: *Please identify any additional assessments required by a Specialist Practitioner and outline the rationale*

Please choose: ☐ Yes (Complete remainder of this section) ☐ No

Additional Assessment #1

Describe assessment required:

Specialist Practitioner Information

Last Name		**First Name**	
Mailing Address			**City/Town**
Province Alberta	**Postal Code**	**Telephone Numbers**	**CPSA or CARNA Registration #**

Upon completion of Required Information and Part A, please fax pages 1- 7 to MAiD Reporting at 403-592-4266 or 1-888-220-2729

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PART B - PROVIDER

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Date of Provision: _____

Section 3: Criminal Code of Canada Eligibility Requirements and Related Information

*The following section lists the eligibility criteria as per the **Criminal Code**, and asks you to indicate compliance by checking the boxes.*

In my opinion:		
1	The patient is eligible for insured services funded by a government in Canada or would be eligible except for a minimum period of residents or waiting period	☐
2	The patient is at least 18 years of age	☐
3	The patient is capable of making decisions with respect to their health	☐
4	The patient has made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure	☐
5	The patient has given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve his or her suffering, including palliative care.	☐
6	The patient has a grievous and irremediable medical condition and all of the following apply: • the patient has a serious and incurable illness, disease or disability; • the patient is in an advanced state of irreversible decline in capability; • the patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to him or her and cannot be relieved under conditions that he or she considers acceptable; • the patient's natural death has become reasonably foreseeable, taking into account all of his or her medical circumstances.	☐

In your opinion, outline below how the patient meets the criteria listed in #6 above.

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Section 3b: Change in Eligibility

To be completed if, in your opinion, the patient was NOT eligible.

Had you previously determined that the patient was eligible for MAID?
☐ Yes ☐ No

If yes, was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health?
☐ Yes ☐ No

If yes, did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)?
☐ Yes ☐ No

Section 4: Procedural Requirements

The following section relates to the safeguards as per the Criminal Code. Please place a check mark (✓) in the middle column where appropriate, and provide relevant details where indicated.

Safeguards as per the Legislation	✓	
I was of the opinion that the patient **met all of the eligibility criteria**. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(a).*	☐	
I ensured that the patient's request for MAID was made in **writing and signed and dated** by the patient, or by another person permitted to do so on their behalf.[4] 4 This requirement refers to the more formal written request which is a legislative safeguard and must be signed, dated and witnessed. To trigger an obligation to report, a written request need not be signed, dated and witnessed. Relevant subsections of the *Criminal Code*: *241.2(3)(b)(i)* and *241.2(4)*.	☐	**If checked**, indicate the date on which the patient (or other person) signed the request Date (yyyy-mm-dd)
I ensured that the request was **signed and dated after the patient was informed** by a physician or nurse practitioner that the patient had a **grievous and irremediable medical condition.** *Relevant subsection of the Criminal Code: 241.2(3)(b)(ii).*	☐	
I was satisfied that the request was signed and dated by the patient or by another person permitted to do so on their behalf, and **before two independent witnesses** who then signed and dated the request. Relevant subsections of the *Criminal Code*: *241.2(3)(c)*, *241.2(4)*, and *241.2(5)*.	☐	
I ensured that the patient was **informed that they may**, at any time and in any manner, **withdraw their request**. Relevant subsection of the *Criminal Code*: *241.2(3)(d)*.	☐	
If the patient had difficulty communicating, I took all necessary measures to provide a reliable means by which the patient may understand the information that is provided to him or her and communicate his or her decision.	☐	N/A ☐

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Section 10: Provincial Reporting Requirements

Indicate compliance by checking the boxes.

I have ensured that:		
1	The patient gives informed consent to medical assistance in dying after having been informed of:	
	a) the diagnosis reached;	☐
	b) the advised interventions and treatments for his or her condition, the exact nature and anticipated benefits of the advised interventions and treatments and their associated common risks and significant risks;	☐
	c) the reasonable alternative treatments available for his or her condition, the exact nature and anticipated benefits of the reasonable alternative treatments and their associated common risks and significant risks;	☐
	d) the exact nature of medical assistance in dying procedure and its associated common risks and significant risks; and	☐
	e) the natural history of his or her condition and the consequences both of receiving and of not receiving medical assistance in dying	☐
2	The patient demonstrates a reasonable understanding of the information provided and the reasonably foreseeable consequences both of receiving and of not receiving medical assistance in dying.	☐
3	I discussed and agreed on a plan with the patient that includes:	
	a) The patient's wishes regarding when, where and how the medical assistance in dying will be provided, including my presence and any additional support.	☐
	b) An alternate plan to address potential complications; and	☐
	c) Informing the patient he or she can withdraw at any time, including immediately before the provision of medical assistance in dying.	☐

Patient plan and Comments *(Please include whether you or another health care profession, including type I known, plan to attend, and the intended setting if known.)*

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Section 4: Declaration of Practitioner Independence

Indicate compliance by checking the boxes.

I have ensured that:	
☐	I ensured that another physician or nurse practitioner provided a written opinion (**second assessmen**t) confirming that the patient met all of the criteria. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(e)*.
☐	I was satisfied that the other practitioner and I are Independent. Relevant subsections of the *Criminal Code*: *241.2(3)(f)* and *241.2(6)*.

Section 11: Independent Medical Opinion

Date Independent Confirmation Occurred *(YYYY/MM/DD)*	Providing Practitioner Initial

Independent medical opinion provided by:

Last Name	First Name	License or Registration #

Type of Practitioner
☐ Physician ☐ Nurse Practitioner

Work Mailing Address			
City/Town	Province AB	Postal Code	Telephone Number

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Section 4: Provision of Medical Assistance in Dying

A patient must be given an opportunity to withdraw their request at any time.

☐ Immediately before providing medical assistance in dying was provided, the patient was given an **opportunity to withdraw** their request and ensured that the patient gave express consent to receive MAID.

☐ I ensured that there were at least 10 clear days between the day on which the request was signed by or on behalf of the patient and the day on which MAID was provided.

Clear days include weekends. In calculating the 10 clear days, the day on which the request was signed and the day on which MAID was provided will not be included. The legislation permits shortening the reflection period in appropriate circumstances.
Relevant subsection of the Criminal Code: 241.2(3)(g).

Date ROR *(YYYY/MM/DD)*	**Date Provided** *(YYYY/MM/DD)*

A period of _____ clear days* has elapsed between the day of which the patient's written request for medical assistance in dying was signed and the day on which the medical assistance in dying was provided

Note: The day on which the request was signed and the day on which medical assistance in dying is provided are not included when calculating the 10 clear day period. For example, if the request is signed on January 1, the 10 clear days elapse on January 12.

*If 10 clear days have not elapsed since the day on which the request for medical assistance in dying was signed:

☐ I and the independent practitioner who provided a written opinion confirming that the patient meets all of the criteria set out in subsection 241.2(1) of the *Criminal Code* (Canada) are both of the opinion that the patient's death, or the loss of the patient's capacity to provide informed consent, is imminent; and

☐ I consider the period that has elapsed since the day on which the request for medical assistance in dying was signed to be appropriate in the circumstances.

Where you considered a shorter period than 10 clear days appropriate in the circumstances, was it the patient's death or loss of capacity to provide informed consent that was deemed imminent (select all that apply)?

☐ Patient's death

☐ Patient's loss of capacity to provide informed consent

☐ I **informed the pharmacist**, before the pharmacist dispensed the substance that I prescribed or obtained, that the substance was intended for the purpose of providing MAID.
Relevant subsection of the Criminal Code: 241.2(8).

Date Prescribed *(YYYY/MM/DD)*	Date Dispensed or unknown *(YYYY/MM/DD)* ☐ Unknown		Pharmacist's First & Last Name	
Pharmacy's Name			Mailing Address	
City/Town	Province AB	Postal Code	Telephone Number	Registration #

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*Only complete if you prescribed or provided a substance for **self-administration***

Section 5: Prescribing or Providing a Substance to the Patient for the Purpose of Self-Administration

I declare that:

☐ I prescribed, and provided to the patient, a drug or drugs that the patient may self-administer for the purposes of causing the patient's death.

Date of prescribing or providing the substance *(YYYY/MM/DD)* *If you both prescribed and provided the substance, use the date that you prescribed.*	Where was the patient staying when you prescribed or provided the substance: ☐ Hospital (exclude palliative care beds or unit) ☐ Palliative care facility (include hospital-based palliative care beds, unit or hospice) ☐ Residential care facility (include long-term care facilities)[4] ☐ Private Residence ☐ Other-specify: _____ ☐ Do not know
Did the patient self-administer the substance (i.e. the substance was ingested) ☐ Yes ☐ No ☐ Do not know *(do not answer questions 5a or b if you answered "do not know")*	

5a: If the patient did self-administer the substance, indicate:

Were you present when the patient self-administered the substance? ☐ Yes ☐ No	Where did the patient self-administer the substance: ☐ Hospital (exclude palliative care beds or unit) ☐ Palliative care facility (include hospital-based palliative care beds, unit or hospice) ☐ Residential care facility (include long-term care facilities)[3] ☐ Private Residence ☐ Other-specify: _____ ☐ Do not know *Note that you are not required to actively seek out this information, but must report if known at the time of reporting.*
On what date did the patient self-administer the substance? (YYYY/MM/DD) ☐ Do not know *Note that you are not required to actively seek out this information, but must report if known at the time of reporting.*	

5b: If the patient did not self-administer the substance, to the best of your knowledge or belief, indicate:

Note: that you are not required to actively seek out this information, but must report if known at the time of reporting.

Did the patient die of a cause other than MAID? ☐ Yes ☐ No ☐ Do not know

If yes, provide the date of death *(YYYY/MM/DD):* _____ ☐ Do not know

[3] Residential care facility means a residential facility that provides health care services, including professional health monitoring and nursing care, on a continuous basis for persons who require assistance with the activities of daily living.

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OR

*Only complete if **you administered** a substance to the patient*

Section 6 : Administering a Substance to the Patient

I declare that:

☐ I administered a drug or drugs to the patient that caused the patient's death.

Date of Administration *(if present)* *(YYYY/MM/DD)*	Time of Administration	Where was the substance administered? ☐ Hospital (exclude palliative care beds or unit) ☐ Palliative care facility (include hospital-based palliative care beds, unit or hospice) ☐ Residential care facility (include long-term care facilities)[4] ☐ Private Residence ☐ Other-specify: _____

To the best of my knowledge, all requirements under federal and provincial legislation and professional standards of practice have been met.

Date: *(YYYY/MM/DD)*	**Providing Practitioner Signature:**

Please retain this form for the patient's medical record.

Upon completion of the provision, please fax a copy of the following:

- **the Record of Request,**
- **Consent to Treatment,**
- **Combined Assessment form/ Providing Practitioner Record**
- **the Record of Medication Administration**

to the appropriate Medical Examiner's office and to Medical Assistance in Dying Regulatory Review Committee Fax: 403-592-4266 or 1-888-220-2729 after medical assistance in dying has been provided.

Medical assistance in dying is provided when:

(a) a practitioner administers drugs that cause a patient's death at the patient's request; or

(b) a practitioner prescribes or provides drugs to a patient, at the patient's request, so that they can self-administer the drugs which will cause their death.

4

[4] Residential care facility means a residential facility that provides health care services, including professional health monitoring and nursing care, on a continuous basis for persons who require assistance with the activities of daily living.