Alberta Health Services

Practitioner Assessment For Medical Assistance in Dying

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.

Upon completion, please fax to MAiD Reporting at **403-592-4266 or 1-888-220-2729**

A. Date of referral: Click here to enter a date.

B. Client/Patient Identifying Information

Last Name	First Name	Middle Name	Gender
Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item.

Date of Birth	Personal Health Number (PHN)	Province of PHN	Postal Code associated to PHN
Click here to enter a date.	Click here to enter text.	Click here to enter text.	Click here to enter text.

C. Assessing Practitioner Information: *Provide your information as the Assessing Practitioner.*

Last Name	First Name	Designation
Click here to enter text.	Click here to enter text.	Choose an item.

If you are a physician - what is your specialty	Other Specialization	CPSA/ CARNA Registration #
Choose an item.	Click here to enter text.	Click here to enter text.

Mailing Address at Primary Place of Work	City/Town	Province	Postal Code
Click here to enter text.	Click here to enter text.	Alberta	Click here to enter text.

Telephone Numbers	Email Address used for work	Have you seen this patient for medical care other than MAiD?
Click here to enter text.	Click here to enter text.	Choose an item.

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

Initial	Practitioner Criteria
Click here to enter text.	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.

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

Date of Assessment: Click here to enter a date.

Choose Response	Mandatory Eligibility Criteria
Choose an item.	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.*
Choose an item.	Was the patient at least 18 years of age?
Choose an item.	Was the patient capable of making decisions with respect to their health?
Choose an item.	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 Click here to enter text.
Choose an item.	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?
Choose an item.	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: Click here to enter text. ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other. *(For stroke, select cardiovascular condition, not neurological condition – other).* Specify: Click here to enter text. ☐ Chronic respiratory disease *(e.g., chronic obstructive pulmonary disease)* ☐ Cardio-vascular condition *(e.g., congestive heart failure, stroke)*. Specify Click here to enter text. ☐ Other organ failure *(e.g., end-stage renal disease)* ☐ Multiple co-morbidities. Specify: Click here to enter text. ☐ Other illness, disease or disability. Specify: Click here to enter text.
Choose an item.	Was the patient in an advanced state of irreversible decline in capability? *This refers to the physical abilities of an individual at this time, not their cognitive abilities.*

Choose an item.	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 Click here to enter text. *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.*
Choose an item.	Had the patient's natural death has become reasonably foreseeable, taking into account all of their medical circumstances?

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 Click here to enter text.
Did the patient **receive** palliative care? ☐ 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? ☐ 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

E. 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
	Click here to enter text.	Click here to enter text.

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:
Click here to enter text.

Assessing Practitioner Signature:	Date: Click here to enter a date.	CPSA or CARNA Registration #: Click here to enter text.

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

Click here to enter text.

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

Please choose: Choose an item.

Additional Assessment #1

Describe assessment required:
Click here to enter text.

Specialist Practitioner Information

Last Name	First Name		
Click here to enter text.	Click here to enter text.		
Mailing Address Click here to enter text.			**City/Town** Click here to enter text.
Province Alberta	**Postal Code** Click here to enter text.	**Telephone Numbers** Click here to enter text.	**CPSA or CARNA Registration #** Click here to enter text.

Additional Assessment #2

Describe assessment required:
Click here to enter text.

Specialist Practitioner Information

Last Name	First Name		
Click here to enter text.	Click here to enter text.		
Mailing Address Click here to enter text.			**City/Town** Click here to enter text.
Province Alberta	**Postal Code** Click here to enter text.	**Telephone Numbers** Click here to enter text.	**CPSA or CARNA Registration #** Click here to enter text.