

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.

Section 1: Basic Information

1a. Client/Patient Identifying Information		
Last Name	First Name	Middle Name
Date of Birth (YYYY/MM/DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Personal Health Number (PHN)

1b. Providing Practitioner Information: <i>Provide your information as the Providing Practitioner.</i>			
Last Name	First Name	Designation <input type="checkbox"/> MD <input type="checkbox"/> NP	
If you are a physician - what is your specialty <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Family Medicine <input type="checkbox"/> General Internal Medicine <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Palliative Medicine <input type="checkbox"/> Respiratory Medicine <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Section 2: 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.

<i>In my opinion:</i>	
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 <input type="checkbox"/>
2	The patient is at least 18 years of age <input type="checkbox"/>
3	The patient is capable of making decisions with respect to their health <input type="checkbox"/>
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 <input type="checkbox"/>
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. <input type="checkbox"/>
6	The patient has a grievous and irremediable medical condition and all of the following apply: <input type="checkbox"/> <ul style="list-style-type: none"> • 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.
<i>I have ensured that:</i>	
7	The patient has been informed that he or she may, at any time or in any manner, withdraw his or her request. <input type="checkbox"/>
8	If the patient has 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. <input type="checkbox"/>
In your opinion, outline below how the patient meets the criteria listed in #6 above.	

Section 3: 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 . <i>Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(a).</i>	<input type="checkbox"/>	
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. ¹ <i>Relevant subsections of the Criminal Code: 241.2(3)(b)(i) and 241.2(4).</i>	<input type="checkbox"/>	If checked , indicate the date on which the patient (or other person) signed the request Click here to enter a date.
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 . <i>Relevant subsection of the Criminal Code: 241.2(3)(b)(ii).</i>	<input type="checkbox"/>	
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. <i>Relevant subsections of the Criminal Code: 241.2(3)(c), 241.2(4) and 241.2(5).</i>	<input type="checkbox"/>	

Other Information	
<p>Did the patient receive palliative care²?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p> <p>If yes, for how long?</p> <p><input type="checkbox"/> Less than 2 weeks <input type="checkbox"/> 2 weeks to less than 1 month <input type="checkbox"/> 1-6 months <input type="checkbox"/> more than 6 months <input type="checkbox"/> Do not know</p> <p>If no, to the best of your knowledge or belief, was palliative care accessible to the Patient?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p>	<p>Did the patient require disability support services³?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p> <p>If yes, did the patient receive disability support services?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p> <p>If yes, for how long?</p> <p><input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 months to less than 1 year <input type="checkbox"/> 1 to less than 2 years <input type="checkbox"/> 2 years or more <input type="checkbox"/> Do not know</p> <p>If no, to the best of your knowledge or belief, were disability support services accessible to the patient?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p>

¹ 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.

² 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.

³ Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

Section 4: 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: <ul style="list-style-type: none"> a) the diagnosis reached; <input type="checkbox"/> 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; <input type="checkbox"/> 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; <input type="checkbox"/> d) the exact nature of medical assistance in dying procedure and its associated common risks and significant risks; and <input type="checkbox"/> e) the natural history of his or her condition and the consequences both of receiving and of not receiving medical assistance in dying <input type="checkbox"/>
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. <input type="checkbox"/>

Section 5: Declaration of Practitioner Independence

Indicate compliance by checking the boxes.

I have ensured that:	
<input type="checkbox"/> I ensured that another physician or nurse practitioner provided a written opinion (second assessment) confirming that the patient met all of the criteria. <i>Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(e).</i>	
Please indicate whether the practitioner who provided a second opinion (second assessment) was a: <input type="checkbox"/> MD <input type="checkbox"/> NP	On what date did the other practitioner sign their written opinion: (YYYY/MM/DD)
I am satisfied that:	
<input type="checkbox"/> I am independent of the person and the referring practitioner, in that I do not know or believe that I am: <ul style="list-style-type: none"> • a mentor to the other practitioner or responsible for supervising their work; • 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. 	

Date Independent Confirmation Occurred (YYYY/MM/DD)

Providing Practitioner Initial

Independent medical opinion provided by:

Last Name		First Name	
Mailing Address			City/Town
Province AB	Postal Code	Telephone Number	Registration #

<p>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):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, indicate what type of professional you consulted (select all that apply):</p> <p><input type="checkbox"/> Nurse <input type="checkbox"/> Oncologist <input type="checkbox"/> Palliative care specialist <input type="checkbox"/> Primary care provider <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Social worker <input type="checkbox"/> Speech pathologist <input type="checkbox"/> Other health care professional. Specify _____</p>
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Section 6: Approval Status

I, and at least one independent practitioner, agree that the patient meets all criteria for medical assistance in dying and approve the request.

(Providing Practitioner)

Yes No

Date (YYYY/MM/DD)

Initial

I discussed and agreed on a plan with the patient that includes:

- The patient's wishes regarding when, where and how the medical assistance in dying will be provided, including my presence and any additional support;
- An alternate plan to address the potential complications; and
- Informing the patient, he or she can withdraw the request anytime, 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.)*

Section 7: 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 (YYYY/MM/DD)	Initial

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.

Initial
Initial

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

<input type="checkbox"/> 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. <i>Relevant subsection of the Criminal Code: 241.2(8).</i>				
Date Prescribed (YYYY/MM/DD)	Date Dispensed or unknown (YYYY/MM/DD)	Pharmacist's First & Last Name		
	<input type="checkbox"/> Unknown			
Pharmacy's Name		Mailing Address		
City/Town	Province AB	Postal Code	Telephone Number	Registration #

Section 8: Prescribing or Providing a Substance to the Patient for the Purpose of Self-Administration

Only complete if you prescribed or provided a substance for 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.

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

8a: If the patient did self-administer the substance, indicate:	
<p>Were you present when the patient self-administered the substance?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Where did the patient self-administer the substance:</p> <p><input type="checkbox"/> Hospital (exclude palliative care beds or unit)</p> <p><input type="checkbox"/> Palliative care facility (include hospital-based palliative care beds, unit or hospice)</p> <p><input type="checkbox"/> Residential care facility (include long-term care facilities)⁴</p> <p><input type="checkbox"/> Private Residence</p> <p><input type="checkbox"/> Other-specify: _____</p> <p><input type="checkbox"/> Do not know</p>
<p>On what date did the patient self-administer the substance? (YYYY/MM/DD)</p> <p><input type="checkbox"/> Do not know</p> <p><i>Note that you are not required to actively seek out this information, but must report if known at the time of reporting.</i></p>	<p><i>Note that you are not required to actively seek out this information, but must report if known at the time of reporting.</i></p>

8b: If the patient did not self-administer the substance, to the best of your knowledge or belief, indicate:	
<p><i>Note: that you are not required to actively seek out this information, but must report if known at the time of reporting.</i></p> <p>Did the patient die of a cause other than MAID? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know</p>	
<p>If yes, provide the date of death (YYYY/MM/DD): _____ <input type="checkbox"/> Do not know</p>	

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.

OR

Section 9: Administering a Substance to the Patient

Only complete if you administered 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 <i>(if present)</i> (YYYY/MM/DD)	Time of Administration	Where was the substance administered? <input type="checkbox"/> Hospital (exclude palliative care beds or unit) <input type="checkbox"/> Palliative care facility (include hospital-based palliative care beds, unit or hospice) <input type="checkbox"/> Residential care facility (include long-term care facilities) ⁵ <input type="checkbox"/> Private Residence <input type="checkbox"/> Other-specify: _____
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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:
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Section 10: Change in Eligibility

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

<p>Had you previously determined that the patient was eligible for MAID? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Please retain this form for the patient's medical record.

Please fax a copy of this form, the Record of Request, Consent to Treatment, and 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.**

⁵ 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.220-2729