Alberta Health Services

Combined Assessment/Providing Practitioner Record For Medical Assistance in Dying

Once complete, **please fax all pages within 24hrs** to MAID Reporting *(if only assessing)* **OR TO** MAID Reporting **AND** Medical Examiner's Office *(if assessing and providing)*

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 ONLY assessing - complete pages 1 - 7 and fax to the MAID Reporting line at 1-403-592-4266 or 1-888-220-2729.**

****If you are assessing AND providing complete all pages 1 - 14 and fax to MAID Reporting line and Medical Examiner's Office.**

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 AB	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?	Date of receipt of written request for MAID *(yyyy-mm-dd)*
☐ Patient Directly ☐ Another practitioner ☐ Care Coordination Service ☐ Another third party – specify: _____	Date I began my MAID assessment *(yyyy-mm-dd)*

Declaration of Practitioner Independence *(Please indicate if you meet the criteria of an independent practitioner)*

Practitioner Criteria

I am independent of the person and the referring practitioner, in that I do not know or believe that I am:

- a mentor to the other practitioner or responsible for supervising their work. ☐ Yes ☐ No
- 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. ☐ Yes ☐ No
- connected to the other practitioner or to the person making the request in any other way that would affect their objectivity. ☐ Yes ☐ No

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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 *(yyyy-mm-dd)*

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? ***For the purposes of this MAID eligibility assessment, a mental illness is not considered to be an illness, disease or disability.*** 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.*

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☐ Yes ☐ No ☐ Did not assess	Had the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances? If **no**, confirm that: ☐ the patient has been informed of the means available to relieve their suffering, including where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professional who provide those services or that care *Relevant subsection of the Criminal Code: 241.2(3.1g)* ☐ I have discussed with the patient the reasonable and available means to relieve their suffering and they have given serious consideration to those means. *Relevant subsection of the Criminal Code: 241.2(3.1h)*

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 ☐ Psychiatrist ☐ Oncologist ☐ Psychologist ☐ Palliative care specialist ☐ Social worker ☐ Primary care provider ☐ Speech pathologist ☐ Other health care professional *(specify)* _____
Did the patient **receive** palliative care[1]? ☐ Yes ☐ No ☐ Do not know ☐ 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. If additional consults were necessary please also complete Part E on page 8.)*

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
Has the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?"	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 Consults/Assessments Required: *Please identify any additional consults/assessments required by Practitioners and outline the rationale*

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

Additional Consult/Assessment #1

☐ the Practitioner had expertise in the condition that was causing the patient's suffering
☐ the Practitioner was consulted for other reason(s) *(Describe reason below)*

Expertise/Specialist Practitioner Information

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

Additional Consult/Assessment #2 *(If required)*

☐ the Practitioner had expertise in the condition that was causing the patient's suffering
☐ the Practitioner was consulted for other reason(s) *(Describe reason below)*

Expertise/Specialist Practitioner Information

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

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PART B - PROVIDER

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Date of Provision *(yyyy-mm-dd)*

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.	☐

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 *(for all patients)*	✓	
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 an independent witness** 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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4b: Safeguards as per the legislation *(ONLY for patients whose natural death NOT reasonably foreseeable)*	✓	
the patient has been informed of the means available to relieve their suffering, including where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professional who provide those services or that care *Relevant subsection of the Criminal Code: 241.2(3.1)(g)*	☐	
I have discussed with the patient the reasonable and available means to relieve their suffering and they have given serious consideration to those means. *Relevant subsection of the Criminal Code: 241.2(3.1)(h)*	☐	

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.	☐
	d) **(OPTIONAL)** If the patient's natural death is reasonably foreseeable, the patient entered into a written agreement with the practitioner that that practitioner would administer a substance to cause the patient's death on or before the specified day, if the patient lost capacity to consent prior to that day.	☐

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

Section 4: Declaration of Practitioner Independence

Indicate compliance by checking the boxes.

I have ensured that:

☐ another physician or nurse practitioner provided a written opinion ***(second assessment)*** 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)*.

Declaration of Practitioner Expertise

(ONLY complete this section if the patient's natural death is NOT reasonably foreseeable)

I have ensured that:

☐ I was satisfied that the other practitioner and/or I had expertise in the condition that is causing the person's suffering **OR**
Relevant subsections of the Criminal Code: 241.2(3.1)(e.1)

☐ a practitioner who has that expertise was consulted the results of which were shared between myself and the other practitioner
Relevant subsections of the Criminal Code: 241.2(3.1)(e.1)

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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

Section 4: Provision of Medical Assistance in Dying

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

Patient's Natural Death Reasonably Foreseeable

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

☐ the patient had lost capacity to consent to receiving MAID AND met all required safeguards for a Waiver of Final Consent as set out in 241.1(3.2) of the Criminal Code of Canada; which include:

- ☐ prior to losing the capacity to consent to receiving MAID they met all eligibility criteria in subsection (1) and all other safeguards set out in subsection (3); **AND**
- ☐ prior to losing this capacity they entered into a written agreement with the practitioner that the practitioner would administer a substance to cause their death on a specified day and were informed of the risk of losing this capacity prior to that day **AND**
- ☐ in the written agreement they consented to the administration by the practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent **AND**
- ☐ the person did not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration; **AND**
- ☐ the substance was administered to the person in accordance with the terms of the written agreement

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Patient's Natural Death NOT Reasonably Foreseeable

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

☐	I ensured that there were at least 90 clear days between the day on which the first assessment began and the day on which MAID was provided. Clear days include weekends. In calculating the 90 clear days, the day on which the first assessment began and the day on which MAID was provided will not be included. The legislation permits shortening this period in appropriate circumstances *Relevant subsection of the Criminal Code: 241.2(3.1)(i).*	**Date 1st Assessment began** *(yyyy-mm-dd)*	**Date Provided** *(yyyy-mm-dd)*

A period of _____ clear days has elapsed between the day of which the patient's first assessment for medical assistance in dying began, and the day on which the medical assistance in dying was provided.

Note: The day on which the first assessment began and the day on which medical assistance in dying is provided are not included when calculating the 90 clear day period. For example, if the request is signed on January 1, the 90 clear days elapse on April 2.

If 90 clear days have not elapsed since the day on which the first assessment for medical assistance in dying began:

☐ 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 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 first assessment for medical assistance in dying to be appropriate in the circumstances.

☐ 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-dd-dd)*		Pharmacist *(first and last name)*	
Pharmacy Name			Mailing Address	
City/Town	Province AB	Postal Code	Phone	Registration #

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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)*[3] ☐ 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,**
- **Waiver of Final Consent (if applicable)**
- **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.

[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.