Alberta Health Services

Last Name *(legal)*	First Name *(legal)*
PHN	Date of Birth *(dd-Mon-yyyy)*

Combined Assessment/Providing Practitioner Record For Medical Assistance in Dying

(Additional follow up questions)

Once complete, please fax all pages within 24hrs to Medical Assistance In Dying Reporting *(if only assessing)*.

If you answered "Yes" to "Did the patient have a serious and incurable illness, disease or disability?"

How long has the patient had a serious and incurable illness, disease or disability?

- ☐ Less than 3 months
- ☐ Between 3 months and less than 1 year
- ☐ Between 1 and less than 5 years
- ☐ Between 5 and less than 10 years
- ☐ Between 10 and less than 20 years
- ☐ 20 years or more
- ☐ Do not know

If you answered "Yes" to "Was the patient in an advance state of irreversible decline in capability?"

What reasons led to your opinion? *(check all that apply)*

- ☐ Unable to do most or all activities of daily living *(ADLs)* and/or instrumental activities of daily living *(IADLs)* or marked decrease in ability to do these activities
- ☐ Reduced or minimal oral intake or difficulty swallowing
- ☐ Dependent on life sustaining treatments *(e.g. transfusions, dialysis, feeding tube, O2, bipap)*
- ☐ Significant dependence on aid*(s)* for interaction *(e.g. hearing aids, magnifying equipment, speech supports, memory strategies)* and/or mobility, or advanced beyond use of these aids or marked increase in dependence
- ☐ Significant shortness of breath or marked increase
- ☐ Persistent significant fatigue/weakness or marked increase
- ☐ Cachexia *(extreme weight loss and muscle wasting due to severe chronic illness, or marked change in weight and/or muscle mass)*
- ☐ Persistent, significant, and escalating chronic pain
- ☐ Other *(specify)* _____

If you answered "Yes" to "Did the patient receive Palliative Care?"

Where did they receive Palliative Care?

- ☐ Home and community care based
- ☐ Hospital-based *(inpatient)*
- ☐ Hospital-based *(palliative care unit)*
- ☐ Hospital-based outpatient or medical clinic/ambulatory service
- ☐ Type C-Hospice care
- ☐ Type A-Long Term Care facility
- ☐ Do not know

What were the types of palliative care received?

- ☐ Pain/symptom management
- ☐ Personal Support Services *(e.g. PSW care)*
- ☐ Volunteer Supports
- ☐ Psychosocial care and/or counselling
- ☐ Spiritual care and/or counselling
- ☐ Palliative Chemotherapy
- ☐ Palliative Radiation Therapy
- ☐ Physiotherapy
- ☐ Occupational therapy
- ☐ Other *(specify)* _____

If you answered "Yes" to "Did the patient receive disability support services?"

What were the types of aids/services that were received? *(check all that apply)*

- ☐ Physical mobility aids *(e.g. walker, wheelchair, cane, scooter)*
- ☐ Audio/visual/communication aids *(e.g. hearing aids, large print materials, magnifiers, communication or write boards, eye gaze technology)*
- ☐ Safety/access/transfers/ADL aids *(e.g. handrails, bath seats, ramps, commode, bed rail, transfer board, lift, adapted utensils)*
- ☐ Income support *(WSIB, CPP-D, ODSP, STD, LTD, insurance settlements)*
- ☐ Mental health/social support professional services *(social work, psychotherapy, counselling, case worker)*
- ☐ Physiotherapy
- ☐ Other *(specify)* _____

Practitioner Name	Date *(dd-Mon-yyyy)*