Newfoundland Labrador

Medical Assistance in Dying (MAiD)
Patient Request Record

Last Name: First Name:

Health Care Number (HCN): Date of Birth(YYYY/MON/DD): Sex: ◯ M ◯ F ◯ UN

Mailing Address: City: Province: Postal Code:

Telephone: Cell:

This section is optional and answering these questions is voluntary – you may choose to answer only some of the questions or none. Your refusal to answer the questions or some of the questions will not affect your care or your eligibility for MAiD. Should you wish to provide personal information, it will remain confidential and will be protected in the same manner as your other health information. If you have any questions on this section, please discuss with your health care practitioner.

Gender: Race: Indigenous Identity:

Do you have a disability? ◯ Yes ◯ No ◯ Do not know ◯ Do not consent to provide the information

A disability may be described as a functional limitation in any one of the following ten areas, which cannot be corrected with the use of aids: seeing, hearing, mobility, flexibility, dexterity, pain-related, learning, developmental, mental health related or memory.

Indicate type of disability (more than one can be selected):

☐ Seeing ☐ Hearing ☐ Mobility ☐ Flexibility ☐ Dexterity

☐ Pain related ☐ Learning ☐ Developmental ☐ Mental health related

☐ Memory and developmental disabilities

Medical Diagnosis Relevant to Request for Assisted Death:

Primary Health Care Provider Name: Telephone:

Contact Persons for Health Care Providers ◯ Self ◯ Preferred Contact

Preferred Contact Name: Relationship: Telephone:

R0052SEP23

Reset Form Print Form

Newfoundland Labrador

Medical Assistance in Dying (MAiD)
Patient Request Record

PATIENT REQUEST

By checking the boxes and signing below, I confirm that:

☐ I am at least 18 years of age and I request MAiD.
☐ I make this request voluntarily and without pressure from others.
☐ I believe that my medical condition is grievous and irremediable, my suffering is intolerable, there are no treatments that I consider acceptable, and I am in an advanced state of irreversible decline.
☐ I have been fully informed of my diagnosis and prognosis and of options for treatments towards cure or control of my condition/disease that may be applicable to my circumstances.
☐ Treatments for symptom control, including the potential benefits of palliative care or other treatment, have been described to me in a manner that I understand.
☐ I consent to be assessed for eligibility and capability by one or more colleagues of my physician or nurse practitioner and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.
☐ I understand that, if I am eligible, my physician or nurse practitioner will administer medications to me by intravenous injection.
☐ I have had an opportunity to ask questions and to request additional information, and have received answers to any questions and responses to any requests.
☐ I understand that I have the right to change my mind at any time.
☐ I expect to die when the medication to be prescribed is administered.

Patient Signature (must be signed in front of the independent witness listed on page 2)

Signature of Patient: _____ Print Name: _____

Date Signed (YYYY/MON/DD): _____

If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction. The proxy cannot be the witness listed on page 2 of this request form.

Last Name: _____ First Name: _____

Health Care Number (HCN): _____ Date of Birth (YYYY/MON/DD): _____

PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the patient and the independent witness listed on page 2)

☐ I am at least 18 years of age.
☐ I understand the nature of this person's request for MAiD.
☐ I am not a beneficiary under the Will of the person making this request for MAiD, or a recipient in any other way of financial or other material benefit resulting from that person's death.
☐ I am signing this document on behalf of _____ in their presence and under their express direction.

Signature of Proxy: Print Name:

Relationship: Date Signed (YYYY/MON/DD): Telephone:

Mailing Address: _____ City: _____ Postal Code: _____ Province: _____

Reset Form Print Form

Newfoundland Labrador

Medical Assistance in Dying (MAiD)
Patient Request Record

CONFIRMATION OF INDEPENDENT WITNESS

By checking the boxes and signing below, I confirm that:

☐ I am at least 18 years of age and understand the nature of the request for MAiD.
☐ The patient is personally known to me or has provided proof of identity.
☐ The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence.
☐ I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or material benefit resulting from the patient's death.
☐ I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides.
☐ I am not directly involved in providing health care services to the patient.*
☐ I do not directly provide personal care to the patient.*
☐ I provide paid personal care or health care services to the patient as my primary occupation and I am not the first or second practitioner involved in the patient's assessment for MAiD; therefore, I did not check the previous two boxes.

***A witness is still considered independent if they provide health care services or personal care to the requestor as their primary occupation and are paid to do so, and are not the assessor, prescriber, or consultant involved in the requestor's assessment for MAiD.**

Independent Witness Signature (Must be signed in the presence of the patient)

Signature of Witness: _____ Print Name: _____

Date (YYYY/MON/DD): _____ Telephone: _____

Mailing Address: _____ City: _____ Province: _____ Postal Code: _____

NEAREST RELATIVE (OPTIONAL)

Name of Nearest Relative: _____ Relation: _____ Telephone: _____

Is this individual aware of the patient's request for MAiD? ☐ Yes ☐ No

Personal health information is collected, used, disclosed and safeguarded in accordance with the **Personal Health Information Act** (PHIA). If you have any questions about the collection or use of this information please contact your Regional MAiD Coordinator.

Please note that there may be circumstances where confidentiality cannot be maintained, such as if the patient exhibits behaviour may cause harm to self or harm to others, or as otherwise required by law. All information shall be treated as confidential unless there is a duty to report under established legal and ethical principles.

Please return a copy of this form to the Regional Health Authority once completed.

Regional MAiD Office Contact Information

Eastern Zone	Phone: 709-777-2250 or 1-833-777-2250	Fax: 709-777-7774	Email: maid@easternhealth.ca
Central Zone	Phone: 709-235-1412	Fax: 709-256-4187	Email: MAiD@centralhealth.nl.ca
Western Zone	Phone: 709-637-5000	Fax: 709-637-5159	Email: maid@westernhealth.nl.ca
Labrador-Grenfell Zone	Phone: 709-897-2350	Fax: 709-896-4032	Email: maid@lghealth.ca

Reset Form Print Form