Newfoundland Labrador

Eastern Health

PATIENT LABEL

Medical Assistance in Dying
PATIENT REQUEST RECORD

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN)	Birthdate (YYYY/MM/DD)	Gender
		☐ Male ☐ Female ☐ Other-Specify:

Patient's Home/Residence Address

Medical Diagnosis Relevant to Request for Assisted Death:

PATIENT REQUEST

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

☐	I am at least 18 years of age and I request medical assistance in dying. 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, I am in an advanced state of irreversible decline, and my death is reasonably foreseeable.
☐	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 and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.
☐	I understand that my physician 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 FOR INITIAL REQUEST (must be signed in front of the two independent witnesses listed on page 2)

Signature of Patient	Print Name	Date Signed

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

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 either of the witnesses listed on page 2 of this request form. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.

Signature of Proxy	Print Name	Relationship
	Date Signed	Phone Number

Address	City	Province	Postal Code

Last Name of Patient	First Name of Patient	Second Name(s) of Patient

CONFIRMATION OF INDEPENDENT WITNESSES

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

Witness 1	Witness 2	
☐	☐	I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
☐	☐	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 and in the presence of the other witness.
☐	☐	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.

SIGNATURE OF INDEPENDENT WITNESSES (must be signed in the presence of the patient and the other witness)

WITNESS 1

Signature of Witness 1	Print Name	Date Signed	Phone Number
	Street Address and City	Province	Postal Code

WITNESS 2

Signature of Witness 2	Print Name	Date Signed	Phone Number
	Street Address and City	Province	Postal Code

NEAREST RELATIVE (OPTIONAL)

Name of Nearest Relative	Relation	Contact Number

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 our office.

When MAiD is administered, please return a copy of this form to Eastern Health.
Please Fax: 777-7774 or scan the form to email address: MAiD@easternhealth.ca

This form was modified from the British Columbia Ministry of Health form HLTH 1632