BRITISH COLUMBIA | Ministry of Health

REQUEST FOR MEDICAL ASSISTANCE IN DYING

1632
2023/09/06

Patient Label

Requestor: submit this form to your medical practitioner or nurse practitioner, or MAiD Care Coordination Service (MCCS). Practitioner: if required, fax or mail a **COPY** of this form to the applicable health authority MCCS. *See bottom of page 2 for MCCS contact information.*

1. REQUESTOR INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Birthdate (YYYY/MM/DD)	Sex at Birth ◯ Male ◯ Female ◯ Intersex

Preferred Gender
◯ Male ◯ Female ◯ X, **Specify:** _____
◯ I do not consent to provide information

Requestor's Home / Residence Address (include City)	Postal Code	Phone Number

Medical Diagnosis Relevant to Request for Medical Assistance in Dying

Primary Health Care Provider (Name) ☐ N/A	Provider Phone Number

Contact Person for MAiD Requests
☐ Myself (Requestor) **and/or** ☐ Other Preferred Contact

Relationship to Requestor	Phone Number

◯ Yes ◯ No ←

If you are approved for MAiD, and you are eligible to donate, would you like to be contacted about the option of organ donation?
(For more information on organ donation, including eligibility criteria, please visit transplant.bc.ca/maid)

This information is collected by the Ministry of Health under s.26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPP Act) and will be used for the purposes of monitoring and oversight for the provision of Medical Assistance in Dying in British Columbia. Should you have any questions about the collection of this personal information, please contact the Manager, Medical Assistance in Dying Oversight Unit at PO BOX 9601 STN PROV GOVT, Victoria BC V8W 9P1; 236-478-1915. Do NOT mail form to this address; send to applicable Health Authority on page 2.

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

2. ADDITIONAL INFORMATION

Federal regulations require that this information be collected to better understand inequality or disadvantage in relation to MAiD. You may indicate that you do not consent to provide this information. This will not affect your eligibility for MAiD.

Do you identify as First Nations, Métis and/or Inuk/Inuit?

- ◯ Yes →
- ◯ No
- ◯ Do not know
- ◯ I do not consent to provide this information

If Yes (check all that apply):

- ☐ First Nations
- ☐ Métis
- ☐ Inuk/Inuit

With which racial, ethnic or cultural group do you identify? (choose all that apply):

- ☐ Black
- ☐ East Asian (Chinese, Korean, Japanese, Taiwanese)
- ☐ Latin American
- ☐ Middle Eastern (Arab, Persian Lebanese, Turkish, etc.)
- ☐ South-east Asian (Filipino, Thai, Vietnamese, etc.)
- ☐ South Asian (Indian, Pakistani, Bangladeshi, etc.)
- ☐ White
- ☐ Another racial, ethnic or cultural group,

  Specify: _____
- ☐ Do not know
- ☐ I do not consent to provide this information

Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see:
https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms

Fraser Health Authority	Phone: 604-587-7878, Fax: 604-523-8855, Email: mccc@fraserhealth.ca https://www.fraserhealth.ca/Service-Directory/Services/end-of-life/medical-assistance-in-dying
Interior Health Authority	Phone: 1-844-469-7073, Fax: 250-469-7066, Email: maid@interiorhealth.ca https://www.interiorhealth.ca/health-and-wellness/palliative-and-end-of-life-care/medical-assistance-in-dying
Northern Health Authority	Phone: 1-888-645-8527, Fax: 250-565-2640, Email: maid@northernhealth.ca https://www.northernhealth.ca/health-topics/medical-assistance-dying-maid
Vancouver Coastal Health Authority http://www.vch.ca/assisted-dying	Phone: 1-844-550-5556, Fax: 1-888-865-2941 Email: AssistedDying@vch.ca
Vancouver Island Health Authority	Phone: 1-877-370-8699, Fax: 250-519-3669, Email: maid@islandhealth.ca https://www.islandhealth.ca/learn-about-health/medical-assistance-dying/medical-assistance-dying
Provincial Health Services Authority	Phone: 1-888-875-3256, Fax: 604-829-2631, Email: maidcco@phsa.ca http://www.phsa.ca/health-info/medical-assistance-in-dying

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

ADDITIONAL INFORMATION continued

In your opinion, do you have a disability?

- ◯ Yes
- ◯ No
- ◯ Do not know
- ◯ I do not consent to provide this information

If Yes, what type(s) of disability do you have? (select all that apply)

- ☐ Seeing
- ☐ Hearing
- ☐ Mobility
- ☐ Flexibility
- ☐ Dexterity
- ☐ Pain-related
- ☐ Learning
- ☐ Developmental
- ☐ Mental health related
- ☐ Memory
- ☐ Other long term condition, **Specify:** _____
- ☐ Do not know
- ☐ I do not consent to provide this information

If Yes, how long have you had your disability?

_____ Years _____ Months ◯ Do not know

◯ I do not consent to provide this information

If Yes, how often does your disability limit daily activity?

◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

◯ Do not know ◯ I do not consent to provide this information

Where is your usual place of residence?

- ◯ Private residence (including retirement home)
- ◯ Hospital (excluding palliative care beds or unit)
- ◯ Palliative care facility (including hospital-based palliative care beds, unit or hospice)
- ◯ Residential care facility (including long-term care facilities)
- ◯ Correctional facility/Prison
- ◯ Shelter/Group Home
- ◯ Other, **Specify** _____

If you live in a private residence, who do you live with?

- ◯ Live with family (partner, children, parents)
- ◯ Live alone
- ◯ Live with relatives
- ◯ Live with non-relatives
- ◯ Other, **Specify** _____

3. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name	First Name	ID Number	Date of Service (YYYY/MM/DD)

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

4. MY REQUEST – *A proxy may initial and sign for you if you are physically unable to sign the request. The Proxy cannot be the same person as the Witness on page 5.

I am eligible for health services funded by a government in Canada, or am in the process of completing a waiting period to become eligible

◯ Yes ◯ No ➔ If Yes: ◯ BC Medical Services Plan ◯ Other, **Specify**:

By initialing and signing below, I confirm that:

Initials	I request medical assistance in dying. I make this request voluntarily, without pressure from others, and if I am found eligible, I expect to die when the prescribed medication is administered.
Initials	I have been informed by a practitioner I have an incurable illness, disease or disability.
Initials	I believe that my medical condition is serious and cannot be relieved by any means I accept.
Initials	Where required by law, I understand that my information will be shared with other health professionals directly involved in my care.
Initials	I can and have the right to change my mind and to ask questions at any time.
Initials	I understand that it is my responsibility to seek advice on my life insurance policy.

5. REQUESTOR SIGNATURE FOR REQUEST (Requestor must sign and date, by hand, in the physical or virtual presence of Independent Witness listed on page 5)

Signature of Requestor	Date Signed (YYYY / MM / DD)	Print Name

PROXY SIGNATURE (IF APPLICABLE) (Proxy must sign and date, by hand, in the PHYSICAL presence of the Requestor and the physical or virtual presence of Independent Witness listed on page 5)

By signing below as the Proxy on behalf of the Requestor, I confirm that:

- I am at least 18 years of age
- I understand the nature of the request for medical assistance in dying
- I do not know or believe that I am 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 the person's death.
- I signed this request for MAiD in the physical presence of the person making the request, on their behalf and under their express direction.

Signature of Proxy	Print Name	Relationship to Requestor
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Prov	Postal Code

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

6. CONFIRMATION OF INDEPENDENT WITNESS (to be completed by witness)

By initialing and signing below, I confirm that:

Initials	**a.** I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
Initials	**b.** The Requestor is personally known to me or has provided proof of identity.
Initials	**c.** The Requestor (or the Proxy in the presence and at the express direction of the Requestor) signed this request in my presence.
Initials	**d.** I do not know or believe that I am a beneficiary under the will of the Requestor, or a recipient, in any other way, of a financial or material benefit resulting from the Requestor's death.
Initials	**e.** I am not an owner or operator of a health care facility where the Requestor is receiving treatment or in which the Requestor resides.
Initials	**f.** I provide **paid** health care services or personal care services to the Requestor as part of my primary occupation and I am **not** the assessor, prescriber or consultant involved in the Requestor's assessment for MAiD.* **OR** I do **not** provide health care services or personal care services directly to the Requestor.*

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.

7. SIGNATURE OF INDEPENDENT WITNESS (Witness must sign and date, by hand, in the physical or virtual presence of the Requestor or Proxy, and on the same date)

Signature of Witness	Print Name	Relationship to Requestor
	Date Signed (YYYY / MM / DD)	Phone Number

Address	City	Prov	Postal Code

Please ensure all of the boxes on the form are completed. To proceed with an assessment of eligibility, submit this form to your physician or nurse practitioner, or contact your health authority's care coordination service for medical assistance in dying (contact information page 2). Please keep a copy of your request form for your records.

Save Print Clear Form