BRITISH COLUMBIA | Ministry of Health

1635
2022/12/15

Medical Assistance in Dying

CONSULTANT'S ASSESSMENT OF PATIENT'S INFORMED CONSENT DECISION CAPABILITY

HLTH 1635

Patient Label

Consultant to fax this assessment to health authority MAiD Care Coordination Service, if required (see below). Retain original in patient's health record, and provide copy to referring practitioner who is responsible for reporting on MAiD to the Ministry of Health.

1. PATIENT INFORMATION

Last Name	First Name	Second Name(s)

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

Preferred Gender
◯ Male ◯ Female ◯ X, **Specify:** ➤ ◯ Does not consent to provide information

2. REFERRING PRACTITIONER

Last Name	First Name	CPSID #	OR	BCCNM #	Phone Number

Mailing Address	City	Postal Code

3. CONSULTANT PRACTITIONER

Last Name	First Name and Initial	College #	Phone Number	Fax Number

Mailing Address	City	Postal Code	Email Address

Specialty (if a family/general practitioner, indicatate your additional training and expertise for an in-person capability assessment)
◯ Psychiatry ◯ Geriatric Medicine ◯ Other - specify:

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

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

5. CONSULTANT PRACTITIONER ASSESSMENT AND DETERMINATION OF PATIENT'S CAPABILITY TO PROVIDE INFORMED CONSENT

Location of Assessment ◯ Home ◯ Facility/Other (specify):	Date(s) of Examinations(s)

☐ I confirm that on this/these dates, I met with the patient and informed them of the reason for this assessment, and I confirmed the patient's consent to conduct an assessment to determine their capability to consent to medical assistance in dying.

Initials	**The patient does not have capability.** A psychiatric illness/cognitive impairment is present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.

OR

Initials	**The patient has capability.** A psychiatric illness/cognitive impairment is **not** present to a degree that impairs ability to make an informed consent decision regarding medical assistance in dying.

I have discussed my findings with the patient, and will advise the referring practitioner.

6. CONSULTANT PRACTITIONER SIGNATURE

Practitioner Signature	Date (YYYY / MM / DD)	Time

THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855, mccc@fraserhealth.ca
Interior HA: Fax: 250-469-7066, maid@interiorhealth.ca
Northern HA: Fax: 250-565-2640, maid@northernhealth.ca
Vancouver Coastal HA: Fax: 1-888-865-2941, AssistedDying@vch.ca
Vancouver Island HA: Fax: 250-519-3669, maid@islandhealth.ca
Provincial Health Services Authority: Fax: 604-829-2631, maidcco@phsa.ca

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.

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