BRITISH COLUMBIA | Ministry of Health

1645
2022/12/21

Medical Assistance in Dying

WAIVER OF FINAL CONSENT

Patient Label

If the Requestor loses capacity and MAiD is administered in accordance to the terms of this agreement, Prescriber must fax this and all required forms to the BC Ministry of Health at 778-698-4678 and to the health authority MAiD Care Coordination Service (if required) **within 72 hours** of confirmation of requestor's death. Retain original in requestor's health records.

Written arrangement between the Requestor named below and the MAiD Prescriber named below for medical assistance in dying in accordance with section 241.2(3.2) of the *Criminal Code of Canada* *(The waiver of final consent is ONLY applicable for individuals whose natural death is reasonably foreseeable)*

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:** ◯ Does not consent to provide information

2. MAiD PRESCRIBER INFORMATION

Name of MAiD Prescriber	CPSID/BCCNM Number	Agreed Date of MAiD Provision (YYYY/MM/DD)

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

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

4. REQUESTOR CONSENT

By initialing and signing below, I confirm that:

Initials	I have been informed by the MAiD Prescriber of the risk of losing capacity to consent to receiving medical assistance in dying.
Initials	I consent to receive a substance administered by the MAiD Prescriber to cause my death, on or before the Agreed Date if I lose capacity to provide consent prior to that day.
Initials	I understand that this arrangement does not require the MAiD Prescriber to proceed with administering medical assistance in dying.

ADDITIONAL TERMS (Optional) MAiD Prescriber **must** be in agreement and MAiD must be provided within the terms of this agreement

Initials	

REQUESTOR SIGNATURE

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

PROXY SIGNATURE (IF APPLICABLE)

The proxy should 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 Requestor, and **should sign in the physical presence of the Requestor**.

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

Address	City	Province	Postal Code

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

5. MAiD PRESCRIBER

Last Name of MAiD Prescriber	First Name of MAiD Prescriber	CPSID/BCCNM Number

REQUESTOR'S CONSENT PROVIDED VIA VERBAL OR OTHER MEANS (IF APPLICABLE)

If consent was provided via verbal or other means and in the absence of a written consent or a proxy, provide details on the steps taken to obtain consent.

I confirm the following safeguards have been met:

Initials	I have informed the Requestor of the risk of losing capacity to consent to receiving medical assistance in dying prior to the agreed day specified in this arrangement.
Initials	The Requestor has consented to the administration of a substance by me to cause their death on or before the day specified in this arrangement if they lose capacity to consent to receiving medical assistance in dying prior to that day.
Initials	The Requestor has acknowleged that I reserve the right to decide against administering medical assistance in dying.

MAiD PRESCRIBER SIGNATURE

By signing below, I confirm I have agreed to provide medical assistance in dying to the Requestor with accordance to the terms and conditions of this arrangement if the patient loses capacity.

Signature of Prescriber	Date Signed (YYYY / MM / DD)

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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