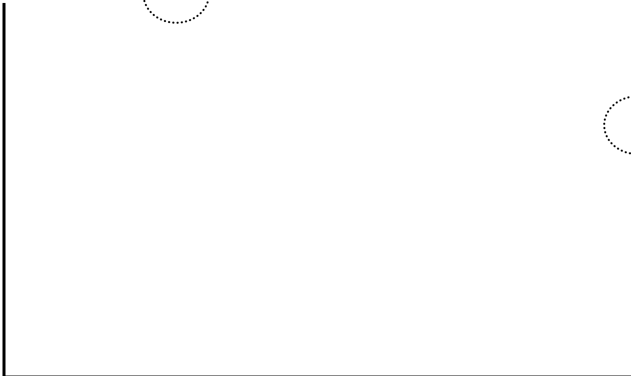
PATIENT REQUEST
Medical Assistance in Dying (MAiD)

Patient Information		
First name	Middle name	Last name
Date of birth (YYYY-MM-DD)	Medicare no.	Medical record no.
Family physician / Nurse practitioner	Telephone	Diagnosis

Patient declaration	
☐	I am suffering from a serious and incurable illness that is causing me unbearable suffering that cannot be relieved in a manner that is acceptable to me.
☐	I request of my own free will to receive medical assistance in dying. This request is being made free from external pressures.
☐	I understand that my request must undergo a minimum of two evaluations by two independent physicians / nurse practitioners who will confirm that I meet the eligibility criteria for medical assistance in dying.
☐	I understand that medical assistance in dying includes medications prescribed by a physician or nurse practitioner that will be administered to me by the physician or nurse practitioner or that I will have to administer myself if I so choose.
☐	I understand that medical assistance in dying may be administered where I reside or in a facility designated by Vitalité Health Network.
☐	I agree for the care team, physicians or nurse practitioners who are evaluating my eligibility for medical assistance in dying to study my medical record. I understand that my documents will be kept for the purposes of surveillance of medical assistance in dying.
☐	I understand that if my death is not reasonably foreseeable, I will have to wait for a period of 90 days from the date of the first evaluation before medical assistance in dying is provided to me.
☐	I understand that I have the right to cancel this request at any time.

Patient name (please print) ______________ Patient signature ______________ YYYY-MM-DD ______________



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Third-party signature (Note: to be completed only if the patient is incapable of signing themselves)	
☐	**I am at least 18 years of age and I understand the nature of the request for medical assistance in dying.**
☐	**I am not, or I do not believe myself to be, the beneficiary of the will and I will not receive any financial or material benefit from the death of the aforementioned person.**
☐	**I am signing this document in the presence and as per the instructions of the aforementioned person.**

Name of third party (please print) ______________________ Signature of third party ______________________ YYYY-MM-DD ____________

Independent witness declaration	
By checking the boxes below, I confirm the following:	
☐	I am at least 18 years of age and I understand the nature of the request for medical assistance in dying.
☐	**I am not the beneficiary of the will and I will receive no financial or other material benefit from the death of the person requesting MAiD.**
☐	I am not the owner or operator of a health care facility or the facility in which the patient resides or receives treatment.
☐	I am not a physician / nurse practitioner who will evaluate the patient's eligibility for MAiD.
☐	I do not provide health or personal care for which I am **not compensated** to the person making this MAiD request.
☐	The patient is requesting of their own free will, free from external pressures, to receive medical assistance in dying.
☐	The aforementioned person (or the third party in the presence of this person) signed the request for medical assistance in dying in my presence.

Name of independent witness (please print) ______________________ Signature of independent witness ______________________ YYYY-MM-DD ____________