

Medical Assistance in Dying (MAiD)

Waiver of final consent

This agreement is concluded between the patient and the physician / nurse practitioner (NP) named below for MAiD, in accordance with the law. **The waiver of final consent applies ONLY to patients whose natural death is reasonably foreseeable.**

Patient information

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

Information on the physician/NP providing MAiD

Physician/NP name	Telephone	Scheduled MAiD date (YYYY-MM-DD)
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Patient declaration

By checking the boxes below, I confirm the following:

<input type="checkbox"/>	I will receive MAiD by an authorized physician/NP on the scheduled date;
<input type="checkbox"/>	I was informed that I am eligible for MAiD based on the criteria established by law and that the safeguard measures have been followed;
<input type="checkbox"/>	I was informed that I am at risk of losing my capacity to consent before the scheduled MAiD date;
<input type="checkbox"/>	I will receive MAiD on the scheduled date even if I no longer have the capacity to consent on that date;
<input type="checkbox"/>	I will receive medication designed to cause my death no later than the day indicated in this agreement if I lose the capacity to consent to MAiD before the scheduled date;
<input type="checkbox"/>	I was informed that this agreement creates no obligation for the physician/NP to administer MAiD if I express through words, sounds or gestures a refusal to receive the medication.

Physician/NP declaration

By checking the boxes below, I confirm the following:

<input type="checkbox"/>	The above-named patient asked me, as an authorized provider, to provide MAiD on the scheduled date;
<input type="checkbox"/>	The above-named patient submitted their request in writing and completed the patient request form (RC-74);

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<input type="checkbox"/>	The above-named patient meets the eligibility criteria and their natural death has become reasonably foreseeable;
<input type="checkbox"/>	I informed the patient of the risk of losing the capacity to consent to MAiD before the scheduled MAiD date;
<input type="checkbox"/>	The above-named patient gave their consent to MAiD on the scheduled date or before even if they have lost the capacity to consent;
<input type="checkbox"/>	The above-named patient gave their consent to receive a substance to cause their death on the scheduled date or before if they lose the capacity to consent;
<input type="checkbox"/>	I consent to provide MAiD to the above-named patient on the scheduled date or before;
<input type="checkbox"/>	I consent to provide the above-named patient MAiD on the scheduled date or before if they lose the capacity to consent to MAiD.

 Signature of patient / third party

 Signature of physician/NP

 YYYY-MM-DD

Additional conditions (optional)		
The patient and physician/NP may agree upon certain additional conditions (e.g. special conditions or circumstances in which MAiD could be provided before on the agreed upon date). Note: The patient and the physician/NP must both agree with these additional conditions.		
Initials of patient / third party	Initials of physician/NP	Additional conditions
Initials	Initials	
Initials	Initials	
Initials	Initials	
Initials	Initials	

 Signature of patient / third party

 Signature of physician/ NP

 YYYY-MM-DD