Name (last, first):	
Birthdate (YYYY/MM/DD):	☐ M ☐ F ☐ Other
HSN:	

Confirmation of Patient's Consent to Medical Assistance in Dying (MAID)
(To be completed immediately prior to administration of MAID)

Section 1: Provision of Consent

Patient Name:

Details of MAID procedure: (Write in full without abbreviations)

☐ Intravenous administration of medications

☐ Oral administration of medications

I confirm that the nature, benefits, risks, consequences, and alternatives of MAID and related matters have been explained to me. I am satisfied with and understand the information I have been given, and I consent to receiving MAID from the Prescribing Practitioner with the assistance of any other healthcare service providers determined appropriate.

I understand that I may, at any time, withdraw consent to MAID or any other related matter. I confirm that the nature, benefits, risks, consequences, and alternatives of MAID and related matters have been explained to me. I am satisfied with and understand the information I have been given, and consent to receiving MAID from the Prescribing Practitioner with the assistance of any other healthcare service providers determined appropriate. Where I have chosen to self-administer MAID using oral medication, I specifically authorize IV administration of MAID medications in the event there are complications that arise from the oral administration.

Signature of Patient	Date (YYYY/MM/DD)	Time

Signature of Proxy if patient is physically unable to sign (Proxy must be at least 18 years old, must understand the nature of the request for MAID and must sign at the patient's express direction and in the patient's presence.)

Signature of Proxy	Name of proxy	Date (YYYY/MM/DD) and Time

Section 2: Withdrawal of Consent

☐ I withdraw my consent for MAID

Signature of Patient	Date (YYYY/MM/DD)	Time

Signature of Proxy if patient is physically unable to sign (Proxy must be at least 18 years old, must understand the nature of the request for MAID and must sign at the patient's express direction and in the patient's presence.)

Signature of Proxy:	Name of proxy:	Date (YYYY/MM/DD)and Time

Note: Health practitioner who has documented the withdrawal of consent should inform the other involved Practitioners of the withdrawal of consent to the treatment plan or procedure.

Section 3: Practitioner Information

Last Name	First Name	Middle Name	Phone Number ( )

Mailing Address at your primary place of work (Street Number, Name, City, and Postal Code):

Work e-mail address:

Province or territory of practice (and within which the written request was received): ☐ Saskatchewan ☐ Other _____

Are you a (choose one):	If you are a physician, what is your area of specialty:	Licence or registration number *If you practice in more than one province or territory, please indicate the licence or registration number for the province or territory in which you received the written request for MAID. This number is the one attributed to you by your College, not your billing number.*
☐ Physician ☐ Nurse practitioner	☐ Anesthesiology ☐ Cardiology ☐ Family medicine ☐ General internal medicine ☐ Geriatric medicine ☐ Nephrology ☐ Neurology ☐ Oncology ☐ Palliative medicine ☐ Respiratory medicine ☐ Psychiatry ☐ Other - specify:	To the best of your knowledge or belief, before you received the written request for MAID, did the patient consult you concerning their health for a reason other than seeking MAID? Yes ☐ No ☐

If MAID provided in acute care facility Practitioner has authority / privileges to provide MAID in SHA.	Practitioner meets requirements of applicable regulatory body to provide MAID.
Yes ☐ No ☐	Yes ☐ No ☐

Section 4: Prescribing/Administering Practitioner Statement

This section must be completed and all requirements must be confirmed before MAID is provided.
The following section relates to the safeguards as per the Criminal Code. Please place a check mark (✓) in the middle column where appropriate, and provide relevant details where indicated.

Safeguards as per the Legislation		Relevant Details (where indicated)
I was of the opinion that the patient **met all of the eligibility criteria**. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(a).*	☐	
I ensured that the patient's request for MAID was made in **writing (using the Written Request for Medical Assistance in Dying form) and signed and dated** by the patient, or by another person permitted to do so on their behalf.[1] *Relevant subsections of the Criminal Code: 241.2(3)(b)(i) and 241.2(4).*	☐	**If checked**, indicate the date on which the patient (or other person) signed the request (YYYY/MM/DD)
I ensured that the request was **signed and dated after the patient was informed** by a physician or nurse practitioner that the patient had a **grievous and irremediable medical condition.** *Relevant subsection of the Criminal Code: 241.2(3)(b)(ii).*	☐	
I was satisfied that the request was signed and dated by the patient or by another person permitted to do so on their behalf, and **before two independent witnesses** who then signed and dated the request. *Relevant subsections of the Criminal Code: 241.2(3)(c), 241.2(4) and 241.2(5).*	☐	
I ensured that the patient was **informed that they may**, at any time and in any manner, **withdraw their request.** *Relevant subsection of the Criminal Code: 241.2(3)(d).*	☐	

[1] This requirement refers to the more formal written request which is a legislative safeguard and must be signed, dated and witnessed. To trigger an obligation to report, a written request need not be signed, dated and witnessed.

I ensured that two written opinions (first and second assessments) have been provided by eligible practitioners (physician or nurse practitioner) confirming that the patient met all of the criteria. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(e).* ☐ Is the prescribing or administering practitioner a different person than either the first or second practitioner? YES ☐ NO ☐ **If yes, PRACTITIONER MUST CONFIRM THE FOLLOWING:** Additional practitioner name: _____ Practitioner meets requirements of applicable regulatory body and Saskatchewan Health Authority to provide MAID. YES ☐ NO ☐ I am satisfied the patient meets the criteria for MAID YES ☐ NO ☐ Additional practitioner signature: _____		Please indicate whether the practitioner who provided each opinion was a physician or Nurse Practitioner (NP) and on what date each assessment was signed: First assessment Second assessment ☐ Physician ☐ Physician ☐ NP ☐ NP Date: mm/dd/yyyy Date: mm/dd/yyyy
I was satisfied that both **practitioners providing written assessments and the prescribing/administering practitioner (if different) are independent as defined by the following:** *Relevant subsections of the Criminal Code: 241.2(3)(f) and 241.2(6).* • Not in a mentoring or supervisory relationship with the other practitioner(s) involved. • Not connected to the other practitioner(s) or patient in any other way that would affect their objectivity. • Not a beneficiary under the patient's will or a recipient in any other way of a financial or other material benefit resulting from the patient's death, other than standard compensation for services	☐ ☐ ☐	
I ensured that there were at least **10 clear days** between the day on which the request was signed by or on behalf of the patient and the day on which MAID was provided, or, any shorter period considered appropriate in the circumstances, if the Prescribing Practitioner, First Assessing practitioner, and Second Assessing practitioner are all of the opinion that the person's death, or the loss of their capacity to provide informed consent is imminent. *Clear days include weekends. In calculating the 10 clear days, the day on which the request was signed and the day on which MAID was provided will not be included. The legislation permits shortening the reflection period in appropriate circumstances. Relevant subsection of the Criminal Code: 241.2(3)(g).*	☐	Where you considered a shorter period than 10 clear days appropriate in the circumstances, was it the patient's death or loss of capacity to provide informed consent that was deemed imminent (select all that apply)? ☐ Patient's death ☐ Patient's loss of capacity to provide informed consent
Immediately before providing MAID, I gave the patient an **opportunity to withdraw** their request and ensured that the patient gave express consent to receive MAID. *Relevant subsection of the Criminal Code: 241.2(3)(h).*		
If the patient had **difficulty communicating**, I took all necessary measures to provide a reliable means by which the patient could have understood the information that was provided to them and communicated their decision. *If the patient did not have difficulty communicating, indicate "n/a" in the next column. Relevant subsection of the Criminal Code: 251.2(3)(i).*		
I **informed the pharmacist**, before the pharmacist dispensed the substance that I prescribed or obtained, that the substance was intended for the purpose of providing MAID.		

Relevant subsection of the Criminal Code: 241.2(8).		
I have credentials/privileges or specific authority issued or granted by the Saskatchewan Health Authority to provide MAID.		
Supplementary Information (please include relevant comments in relation to the above section):		

Procedural Requirements Have Been Met	
To the best of my knowledge, all of the procedural requirements under federal legislation have been met.	
Practitioner's Signature	Date (YYYY/MM/DD)

Section 5: Administering a Substance to the Patient *Only complete if you administered a substance to the patient*	
On what date did you administer the substance? (YYYY/MM/DD) Time between medication administration and death:	Where did you administer the substance? ☐ Hospital (exclude palliative care beds or unit) ☐ Palliative care facility (include hospital-based palliative care beds, unit, or hospice) ☐ Residential care facility (include long-term care facilities) ☐ Private residence ☐ Other- specify: Was the patient moved because of conscientious objection (CO)? ☐ No ☐ Yes- facility related ☐ Yes-MRP or GP related

Section 6: Providing a Substance to the Patient for the Purpose of Self-Administration *Only complete if you provided a substance for self-administration*	
On what date did you provide the substance for self-administration *(YYYY/MM/DD)*	Where did you provide the substance for self-administration? ☐ Hospital (exclude palliative care beds or unit) ☐ Palliative care facility (include hospital-based palliative care beds, unit, or hospice) ☐ Residential care facility (include long-term care facilities)[2] ☐ Private residence ☐ Other-specify:
If the patient self-administered the substance (i.e., the substance was ingested): I confirm that I was present when the patient self-administered the substance and available until the death of the patient. ☐ Time between medication administration and death:	If the patient did not self-administer the substance: Did the patient change his or her mind after the initial re-consent? ☐ Yes ☐ No Did the patient die of a cause other than MAID after the initial re-consent? ☐ Yes ☐ No **If yes,** provide the date of death: (YYYY/MM/DD) ☐ Do not know Note that you are not required to actively seek out this information, but must report if known at the time of reporting.

[2] Residential care facility means a residential facility that provides health care services, including professional health monitoring and nursing care, on a continuous basis for persons who require assistance with the activities of daily living.

	Other reason for the patient not self-administering the medications after initial re-consent:

Section 7: Supplementary Information *Provide supplementary information to clarify your responses, if applicable.*