First Assessment Form for Physician and Nurse Practitioners

Section 1: Basic Information

1a. Patient Information

Last Name	First Name	Middle Name

Date of birth (YYYY/MM/DD)	Sex □ Male □ Female □ Other	Health services number □ Not applicable

Province or territory that issued the health services number *If the patient does not have a health services number, please indicate the province or territory of their usual place of residence on the day the practitioner received the written request.*	Postal code associated with the patient's health services number *If the patient does not have a health services number, please indicate the postal code of their usual place of residence on the day the practitioner received the written request.*

1b. 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):

Are you a (choose one): □ Physician □ Nurse practitioner	If you are a physician, what is your area of specialty: □ Anesthesiology □ Cardiology □ Family medicine □ General internal medicine □ Geriatric medicine □ Nephrology □ Neurology □ Oncology □ Palliative medicine □ Respiratory medicine □ Psychiatry □ Other - specify:	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.* 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. Yes □ No □	Practitioner meets requirements of applicable regulatory body to provide MAID. Yes □ No □

1c. Receipt of the Written Request

From whom did you receive the written request for MAID that triggered the obligation to provide information? □ Patient directly □ Another practitioner □ Care coordination service □ Another third party- specify:	Date of receipt of written request for MAID (YYYY/MM/DD)

Section 2a: Eligibility Criteria and Related Information

- *To be completed if:*
  - *a) you provided MAID;*
  - *b) you found the patient to be ineligible for MAID;*
  - *c) the patient withdrew the request after you found them to be eligible for MAID, or*
  - *d) you became aware of the patient's death from a cause other than MAID after you found them to be eligible for MAID.*
- *The following section lists the federal eligibility criteria as per the **Criminal Code**, and asks you to indicate whether you assessed it and, if so, your opinion as to the patient's eligibility, with relevant details where specified.*
- *This section also includes additional federal reporting requirements and SK specific reporting requirements that are intended to inform the assessment process.*
- *A practitioner will not necessarily assess all criteria for every request. If a patient is ineligible based on one criterion, the practitioner may not have assessed the remaining criteria. **THE 'DID NOT ASSESS' BOX CAN ONLY BE USED WHERE A PATIENT IS FOUND TO BE INELIGIBLE BASED ON ONE OF THE CRITERION AND ASSESSMENT OF REMAINDER CEASED.***

Federal Eligibility Criteria		If you assessed the criterion, provide relevant details, where indicated
Was the patient eligible for health services funded by a government in Canada? *Answer "Yes" if the patient would have been eligible but for an applicable minimum period of residence or waiting period.*	□ Yes □ No □ Did not assess	
Was the patient at least 18 years of age?	□ Yes □ No □ Did not assess	
Was the patient capable of making decisions with respect to their health?	□ Yes □ No □ Did not assess	
Did the patient make a voluntary request for MAID that, in particular, was not made as a result of external pressure?	□ Yes □ No □ Did not assess	**If yes,** indicate why you are of this opinion (select all that apply): □ Consultation with patient □ Knowledge of patient from prior consultations or treatment for reasons other than MAID □ Consultation with other health or social service professionals □ Consultation with family members or friends □ Reviewed medical records □ Other – specify:
Did the patient give informed consent to receive MAID after having been informed of the means that were available to relieve their suffering, including palliative care[1]?	□ Yes □ No □ Did not assess	

[1] Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of pain and other physical symptoms, and psychosocial and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.

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Did the patient have a serious and incurable illness, disease or disability?	□ Yes □ No □ Did not assess	**If yes**, indicate the illness, disease or disability – (select all that apply): □ Cancer – lung and bronchus □ Cancer – breast □ Cancer – colorectal □ Cancer – pancreas □ Cancer – prostate □ Cancer – ovary □ Cancer – hematologic □ Cancer – other. Specify: □ Neurological condition – multiple sclerosis □ Neurological condition – amyotrophic lateral sclerosis □ Neurological condition – other (*For stroke, select cardio-vascular condition, **not** neurological condition- other).* Specify: □ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) □ Cardio-vascular condition (e.g., congestive heart failure, stroke). Specify: □ Other organ failure (e.g., end-stage renal disease) □ Multiple co-morbidities. Specify: □ Other illness, disease or disability. Specify:
Was the patient in an advanced state of irreversible decline in capability?	□ Yes □ No □ Did not assess	
Did the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that was intolerable to them and could not be relieved under conditions that they considered acceptable?	□ Yes □ No □ Did not assess	If yes, indicate how the patient described their suffering (select all that apply): □ Loss of ability to engage in activities making life meaningful □ Loss of dignity □ Isolation or loneliness □ Loss of ability to perform activities of daily living (e.g. bathing, food preparation, finances) □ Loss of control of bodily functions □ Perceived burden on family, friends or caregivers □ Inadequate pain control, or concern about it □ Inadequate control of other symptoms, or concern about it □ Shortness of breath or dyspnea □ Previous negative experience with death □ Other – specify:
Had the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances without a prognosis necessarily having been made as to the specific length of time that they have remaining?	□ Yes □ No □ Did not assess	

Other Information Required through Federal Monitoring Regulations	
Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory written second assessment required by the *Criminal Code*)? □ Yes □ No *Note: consulting other health care professionals is not a requirement of the Criminal Code when assessing eligibility.*	**If yes**, indicate what type of professional you consulted (select all that apply): □ Nurse □ Oncologist □ Occupational Therapist □ Palliative care specialist □ Primary care provider □ Psychiatrist □ Psychologist □ Social worker □ Speech pathologist □ Other health care professional-specify:
Did the patient receive palliative care[2]? □ Yes □ No □ Do not know **If yes,** for how long? □ Less than 2 weeks □ 2 weeks to less than 1 month □ 1-6 months □ more than 6 months □ Do not know **If no,** to the best of your knowledge or belief, was palliative care accessible to the patient? □ Yes □ No □ Do not know	Did the patient **require** disability support services[3]? □ Yes □ No □ Do not know **If yes**, did the patient **receive** disability support services? □ Yes □ No □ Do not know **If yes**, for how long? □ Less than 6 months □ 6 months to less than 1 year □ 1 to less than 2 years □ 2 years or more □ Do not know **If no,** to the best of your knowledge or belief, were disability support services accessible to the patient? □ Yes □ No □ Do not know

SK Reporting Requirements to Inform Assessment Process & Ensure Compliance with Eligibility Requirements	
Has the patient made his/her decision to receive MAID after being fully informed of:	
• His/her medical diagnosis?	□ Yes □ No
• All available treatment options?	□ Yes □ No
• The potential risks and probable consequences associated with being administered the medication to be prescribed?	□ Yes □ No
• The expected result of being administered the medication to be prescribed?	□ Yes □ No
Has the patient had an opportunity to ask questions and to request additional information, and received answers to any questions and responses to any requests?	□ Yes □ No
Does the patient understand the information given and that it applies to them?	□ Yes □ No
Did you discuss with the patient whether or not they will inform their family/social network?	Did you discuss and agree on a plan with the patient regarding:

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[3] Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

□ Yes □ No	The manner in which MAID will be provided, including that you will be present? □ Yes □ No How potential complications will be addressed, should they arise, including, in cases of oral self-administration, the potential need for IV administration to occur if there are complications with the oral administration? □ Yes □ No
Capacity Evaluation (*Check one of the following)*	
I have determined that the patient **is not** suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment and has capacity to give informed consent.	☐
I have determined that the patient **is** suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, but continues to have the capacity to give informed consent.	☐
I have determined that the patient **is** suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment and does not have the capacity to give informed consent and is not eligible for MAID:	☐ At this time ☐ Not at all
I have **referred** the patient to the provider listed below for evaluation and counselling for a possible psychiatric or psychological disorder, or depression, causing impaired judgment/capacity, **and have attached the consultant's completed form**.	☐
Date (YYYY/MM/DD)	Consultant name
Phone Number ( )	Date of Referral (YYYY/MM/DD)
Supplementary Information (Please include any additional comments on the above information)**:**	

Second Practitioner Assessment requested from:
Attach Second Assessment Form

Last Name	First Name	Phone Number ( )
		Date of Referral (YYYY/MM/DD)

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

Section 2b: Change in Eligibility

To be completed if, in your opinion, the patient was NOT eligible.

Had you previously determined that the patient was eligible for MAID?

□ Yes □ No

IF YES,

Was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health?

□ Yes □ No

Did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)?

□ Yes □ No

Eligibility Requirements Have Not Been Met	
Practitioner's Signature	Date (YYYY/MM/DD)
Comments:	

*The Saskatchewan Health Authority is named in the federal regulations as a provincial designate. This form must be faxed to 1-833-837-9006 within federally required timelines.

* If you have any questions about the completion of this form or reporting obligations, please call the SK Health Authority at 1-833-473-6242.