Patient Withdrawal of Request – Death From Another Cause
Physician/Nurse Practitioner Form

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 □

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)

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Section 2: Eligibility Criteria and Related Information • *Section 2 is only to be completed if (1) the patient withdrew their request for MAID or died from a cause other than MAID, and (2) had previously been found to be eligible for MAID.*		
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	
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

[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.

		□ 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	

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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	**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

Section 3: Withdrawal of Request *Only complete if you became aware that the patient withdrew his or her request.* *For the purposes of monitoring, "withdrew the request" means that, to the best of the practitioner's knowledge, the patient does not intend to pursue their request for medical assistance in dying. The withdrawal may take any form (e.g., oral or in writing). A lack of contact with the patient would not be sufficient to assume that he or she had withdrawn the request and would not require the provision of information. You are not required to actively seek out information about whether the patient has withdrawn their request, but must report if known at the time of reporting.*	
What were the patient's reasons for withdrawing the request (select all that apply): □ Palliative measures are sufficient □ Family members do not support MAID □ Changed their mind □ Other- specify: □ Do not know	Did the patient withdraw their request after being given an opportunity to do so immediately before providing MAID, as per Section 241.2(3)(h) of the *Criminal Code*? □ Yes □ No
Date you became aware the patient withdrew the request (YYYY/MM/DD):	

[2] 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.
[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.

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Section 4: Patient Died of Cause other than Medical Assistance in Dying *Only complete if you became aware that the patient died of a cause other than MAID and had not prescribed or provided a substance for self-administration. You are not required to actively seek out information about whether the patient has died of a cause other than MAID, but must report if known at the time of reporting.*	
Did you complete the death certificate? □ Yes □ No	
If yes, what was the date of death? (YYYY/MM/DD) What is the immediate cause of death indicated on the death certificate? What is the underlying cause of death indicated on the death certificate?	**If no,** provide the date of death (YYYY/MM/DD) □ Do not know
Date you became aware the patient died from another cause (YYYY/MM/DD):	

Section 5: Supplementary Information *Provide supplementary information to clarify your responses, if applicable.*

*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.