Second Assessment Form for Physician and Nurse Practitioners

PLEASE PRINT

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	Postal code associated with the patient's 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.	*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. Second Assessment 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 □

Section 2: Referring Practitioner

Registration #:

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

Section 3: Second Assessment

Assessment of Eligibility

Medical diagnosis relevant to request for assisted death	Date of Examination(s) (YYYY/MM/DD)

Indicate compliance with Legal Requirements by checking the boxes.

1.	The patient has a grievous and irremediable medical condition:		
	a. Does the patient have a serious and incurable illness, disease, or disability?	□ Yes	□ No
	b. Is the patient in an advanced state of irreversible decline in capability?	□ Yes	□ No
	c. Does the patient's illness, disease, or disability, or their state of decline cause them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they considered acceptable?	□ Yes	□ No
	d. Has 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
2.	Is the patient at least 18 years of age?	□ Yes	□ No
3.	Is the patient capable* of making decisions with respect to their health? **"Capable" means that a patient understands the nature, purpose, benefits, risks, and foreseeable consequences of a health care decision and understands that the information applies to them.*	□ Yes	□ No
4.	Is the patient making a voluntary request for MAID that, in particular, is not made as a result of external pressure?	□ Yes	□ No
5.	Has the patient been informed of his/her right to withdraw his/her request for MAID at any time and in any manner?	□ Yes	□ No
6.	Has the patient made his/her decision 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
	• The feasible alternatives and treatments, including, but not limited to, palliative care?	□ Yes	□ No
7.	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
8.	Does the patient understand the information given and that it applies to him/her?	□ Yes	□ No
9.	Is the patient eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada.	□ Yes	□ No
10.	Did you discuss with the patient whether or not they will inform their family/social network?	□ Yes	□ No

X	initial

Section 4: Capacity Evaluation

*Check one of the following **(required):***

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 counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment/capacity, **and have attached the consultant's completed form**. ☐

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

Section 5: Second Assessment Practitioner Declaration

I declare that:

- I am not in a mentoring or a supervisory relationship with the referring practitioner; and
- To my knowledge:
  - I am 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; and,
  - I am not connected to the referring practitioner or to the patient in any other way that would affect my objectivity.

X	Signature:	Date (YYYY/MM/DD):

*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.