If Patient completes service, send copy of Form to Saskatchewan HealthLine Fax 306-766-6006

WRITTEN REQUEST FOR MEDICAL ASSISTANCE IN DYING (MAID)

A Patient Information			
Last Name:	First Name:	Middle Name :	Date of Birth (YYYY/MM/DD): Sex: F ☐ M ☐
Address (Street Number, Name, City, Province, and Postal Code):			Phone number:
Medical Diagnosis relevant to request for assisted death:			HSN:

REQUEST FOR MAID AND BACKGROUND (*Initial all boxes in the presence of the witnesses. Witnesses do not need to read, hear or review the content.*)

I, Click here to enter text. , am an adult over 18 years of age and I voluntarily consent to the termination of my life. (Print full name)

Initial

I believe, and my physician/nurse practitioner has determined and advised me, that my medical condition is grievous and irremediable. This condition is intolerable to me and cannot be relieved under conditions acceptable to me. ☐

I have been fully informed of my diagnosis and prognosis and of options for treatment towards cure or control of my condition/disease, that may be applicable to my circumstances. ☐

I have been advised of and understand the available treatments for symptom control, the methods available to relieve my suffering and the potential benefits of palliative care. ☐

I have had an opportunity to ask questions and to request additional information and have received answers to any questions and responses to any requests. ☐

I request that my physician/nurse practitioner prescribe medication(s) that I may self-administer or which may be administered to me, which will end my life, and to contact a pharmacist to fill the prescription. ☐

CONSULTATION WITH FAMILY (initial appropriate box)

Initial **One**

I have informed my family/social network of my decision. ☐

I have decided not to inform my family/social network of my decision. ☐

I have no family/social network to inform of my decision. ☐

PRIVACY ISSUES, UNDERSTANDING AND CONSENT

The Health Information Protection (HIPA) Act states that health information will only be collected, used, and disclosed in accordance with that Act. Such could involve discussion with your primary health care team, such as your family physician, your inpatient clinical team (nursing, care aides, social work, etc.), as well as closely involved community health care providers (such as palliative care). After your death, these team members (and your family members, if you wish us to involve them) may also be involved in debriefing, which allows us to provide them support, but also allows us to improve our clinical care in the future. In addition information will need to be reported to the Federal Government as required by regulations under the Criminal Code. If you have specific privacy wishes, please provide details. We will try our best to meet your requests, but this may be limited by clinical care needs to ensure safe delivery of MAID.

Initial all boxes in the presence of the witnesses. Witnesses do not need to read, hear or review the content.

I understand that I have the right to change my mind at any time. ☐

I understand the full impact of this request, including the foreseeable consequences of my decision, and I expect to die when the medication to be prescribed is administered. ☐

I make this request voluntarily and without pressure from others. ☐

I understand the procedure by which medical assistance in dying will be provided and the risks and possible consequences of taking the medication that will be prescribed. ☐

I understand that practical details (like the scheduling and the location of MAID) are dependent on provider availability and facility factors ☐

Patient Signature

Print name:	Signature:	Date (YYYY/MM/DD): Click here to enter a date.

Patient may sign by Proxy if patient is physically unable to sign. Proxy can only sign on the patient's express direction and in the patient's presence. Proxy cannot be the same person as a witness.

Declaration of Proxy

By *initialing* and *signing* below, I declare that I am at least 18 years of age, that I understand the nature of the request for medical assistance in dying, and that:

1. To my knowledge, I am not a beneficiary under the will of the patient or a recipient in any other way of a financial or material benefit resulting from the patient's death ☐

Proxy Signature

Print name:	Signature:	Date (YYYY/MM/DD):

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Declaration of Independent Witnesses

By *initialing* and *signing* below, I declare that I am at least 18 years of age and understand the nature of the request for medical assistance in dying, and that:

	Witness 1	Witness 2
1. The patient is personally known to me or has provided proof of identity;		
2. The patient initialed and signed this request in my presence, on the date following the patient's signature; or if the patient was unable to do so, the patient's proxy initialed and signed this request at the patient's direction in my presence and in the presence of the patient, on the date following the proxy's signature;		

I declare that:

1. To my knowledge, I am not a beneficiary under the will of the patient or a recipient in any other way of a financial or material benefit resulting from the patient's death;		
2. I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides;		
3. I am not directly involved providing health care services to the patient;		
4. I do not directly provide personal care to the patient.		

Witness Signatures

Witness Signatures		
Witness 1		
Print Name	Signature	Date (YYYY/MM/DD)
Street	City, Province, Postal Code	Phone #
Witness 2		
Print Name	Signature	Date (YYYY/MM/DD)
Street	City, Province, Postal Code	Phone #

Please retain this form in the patient's medical record.