POLICY

Medical Assistance in Dying

STATUS:	APPROVED
Approved by Council:	Sept 17, 2016
Amended:	November, 2018
To be reviewed:	November, 2021

Background

On February 6, 2015, the Supreme Court of Canada struck down the law prohibiting medical assistance in dying.[1] The Canadian Government amended the Criminal Code provisions effective June 17, 2016.[2] The legislation contains a number of requirements that must exist for physicians or nurse practitioners to provide medical assistance in dying. The most important of those are:

1) The patient must be eligible for health services funded by a government in Canada;
2) The patient must be at least 18 years of age and capable of making decisions with respect to their health;
3) The patient must have a grievous and irremediable medical condition;
4) The patient must have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure;
5) The patient must have given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care;
6) Two practitioners (physicians or nurse practitioners) must confirm that the patient meets the criteria established in the legislation to receive medical assistance in dying.

[1] Carter v. Canada (Attorney General), 2015 SCC 5; https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1

[2] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* http://laws-lois.justice.gc.ca/PDF/2016_3.pdf

The legislation states that a person has a grievous and irremediable medical condition only if they meet all of the following criteria:

1) They have a serious and incurable illness, disease, or disability;

2) They are in an advanced state of irreversible decline in capability;

3) That illness, disease, disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable;

4) Their natural death has 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 they have remaining.

The federal government has indicated that medical assistance in dying is intended to be restricted to those individuals who are declining towards death, allowing them to choose a planned death.

The new legislation contains a number of other provisions that provide protection to individuals involved in assisting patients to access medical assistance in dying. Among those are:

1) Protection for physicians and nurse practitioners who provide medical assistance in dying based upon a reasonable but mistaken belief that the patient qualified;
2) Protection for pharmacists and other health care workers who assist with medical assistance in dying;
3) Protection for individuals who provide information to patients about medical assistance in dying;
4) Protection for individuals who assist patients to self-administer medication that has been prescribed to them for the purpose of medical assistance in dying.

The College of Physicians and Surgeons of Saskatchewan has established this policy for the following purposes:

1) To provide information that will assist physicians and the public in understanding the criteria and procedural requirements that must be met regarding medical assistance in dying; and
2) To outline the specific legal requirements to participate in medical assistance in dying and to establish expectations of physicians who are involved with medical assistance in dying.

Definitions

Medical Assistance in Dying (MEDICAL ASSISTANCE IN DYING) is defined in s. 241.1 of the *Criminal Code* to mean:

1) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
2) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Foundational Principles

The foundational principles used by the College in developing this document include:

1) *Respect for patient autonomy*: Competent adults are free to make decisions about their bodily integrity. Given the finality of medical assistance in dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent and consistency with the principles established by Canadian Law;

2) *Access*: Individuals who seek information about medical assistance in dying should have access to unbiased and accurate information. To the extent possible, all those who meet the criteria for medical assistance in dying and request it should have access to medical assistance in dying;

3) *Respect for physician values*: Within the bounds of existing standards of practice, and subject to the expectations in this document and the obligation to practise without discrimination as required by the CMA *Code of Ethics* and human rights legislation, physicians can follow their conscience when deciding whether or not to provide medical assistance in dying;

4) *Consent and capacity*: All the requirements for informed consent must clearly be met. Consent is seen as an evolving process requiring physicians to continuously communicate with the patient. Communications include exploring the priorities, values and fears of the patient, providing information related to the patient's diagnosis and prognosis, providing treatment options including palliative care interventions and answering the patient's questions. Consent must be express and voluntary. Given the context, a patient's decisional capacity must be carefully assessed to ensure that the patient is able to understand the information provided and understands that the consequences of making a decision to access medical assistance in dying;

5) *Clarity:* Medical Regulatory Bodies should ensure, to the extent possible, that guidance or standards which they adopt:

   a) provide guidance to patients and the public about the requirements which patients must meet to access medical assistance in dying;
   b) advise patients what they can expect from physicians if they are considering medical assistance in dying; and,
   c) clearly express what is expected of physicians.

6) *Dignity*: All patients, their family members and significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life;

7) *Accountability:* Physicians participating in medical assistance in dying must ensure that they have appropriate technical competencies as well as the ability to assess decisional capacity, or the ability to consult with a colleague to assess capacity in more complex situations;

8) *Duty to Provide Care:* Physicians have an obligation to provide ongoing care to patients unless their services are no longer required or wanted or until another suitable physician has assumed responsibility for the patient. Physicians should continue to provide appropriate and compassionate care to patients throughout the dying process regardless of the decisions they make with respect to medical assistance in dying.

1. Conscientious Objection

A physician who declines to provide medical assistance in dying must not abandon a patient who makes this request; the physician has a duty to treat the patient with dignity and respect. The physician is expected to provide sufficient information and resources to enable the patient to make his/her own informed choice and access all options for care. This means arranging timely access to another physician or resources, or offering the patient information and advice about all the medical options available. Physicians must not provide false, misleading, intentionally confusing, coercive or materially incomplete information, and the physician's communication and behaviour must not be demeaning to the patient or to the patient's beliefs, lifestyle choices or values. The obligation to inform patients may be met by delegating this communication to another competent individual for whom the physician is responsible.

A physician who declines to provide medical assistance in dying must make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing medical assistance in dying to the patient when authorized by the patient to do so; and document the interactions and steps taken by the physician in the

patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

2. Requirements for Access to Medical Assistance in Dying:

Federal legislation requires that to be eligible for medical assistance in dying, the patient must meet all of the following criteria:

a) be eligible for publicly funded health services in Canada;

b) be at least 18 years of age and capable of making decisions with respect to their health;

c) have a grievous and irremediable medical condition (including an illness, disease or disability); and

d) make a voluntary request for medical assistance in dying that is not the result of external pressure; and

e) provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve the patient's suffering, including palliative care.

According to the federal legislation, a person has a grievous and irremediable medical condition only if **all** of the following criteria are met:

a) they have a serious and incurable illness, disease or disability;

b) they are in an advanced state of irreversible decline in capability;

c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and,

d) their natural death has 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.

The College requires that:

A. Any physician who conducts an assessment for the purpose of determining if a patient is eligible for medical assistance in dying pursuant to these requirements must:

1. have received approval from the Saskatchewan Health Authority or the College to perform assessments for the purpose of determining if a patient is eligible for medical assistance in dying: and,

2. be satisfied that the patient seeking medical assistance in dying has a grievous and irremediable medical condition which the physician has verified by:

    a. a clinical diagnosis of the patient's medical condition; and

    b. a thorough clinical assessment of the patient which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician;

3. be fully informed of the current relevant clinical information about the patient and his/her condition;

4. be qualified to render a diagnosis and opine on the patient's medical condition or be able to consult with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options;

5. use appropriate medical judgment and utilize a reasonable method of assessment;

6. when assessing whether a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, ensure that:

    a. the unique circumstances and perspective of the patient, including his/her personal experiences and religious or moral beliefs and values have been seriously considered;

    b. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

    c. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and the patient adequately understands the:

        1. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and

        2. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and

3. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.

B. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for medical assistance in dying.

3. Specific Requirements for Assessing Medical Decision Making Capacity

A. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect to their health pursuant to the federal requirements must be:

1. fully informed of the current relevant clinical information about the patient and his/her mental and physical condition; and

2. able to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity.

B. When it is unclear whether the patient is competent to make a decision to request medical assistance in dying, a psychiatric/psychological consult is required to examine the patient's decision-making capacity (or limitations) in greater detail.

C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessments of a patient's medical decision making capacity.

4. Specific Requirements for Obtaining Informed Consent

The federal legislation requires that before a physician provides medical assistance in dying, the physician must:

(a) ensure that the request for medical assistance in dying was:

i. made in writing and signed and dated by:

a. the patient; or

b. where the patient is unable to sign and date the request, by another person (proxy) at the express direction of and in the presence of the patient. The person who serves as the proxy must:

1. be at least 18 years of age;

2. understand the nature of the request for medical assistance in dying;

3. not know or believe that they are a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death; and

ii. signed and dated after the patient was informed by a physician or nurse practitioner that the patient has a grievous and irremediable medical condition.

(b) be satisfied that the request was signed and dated by the patient or by the patient's proxy before two independent witnesses who then also signed and dated the request;

(c) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

(d) ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria and be satisfied that they and the other physician or nurse practitioner providing the opinion are independent in that each of them:

i. is not a mentor to the other practitioner or responsible for supervising their work;

ii. does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; or

iii. does not know or believe that they are connected to the other practitioner or to the patient in any other way that would affect their objectivity;

(e) ensure that there are **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 medical assistance in dying is provided or — if they and the other physician or nurse practitioner are both of the opinion that the patient's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first physician or nurse practitioner considers appropriate in the circumstances;

(f) immediately before providing medical assistance in dying, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying;

(g) be satisfied that the patient remains capable at the time the patient will receive medical assistance in dying;

(h) if the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.

The federal legislation also provides that any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if that person:

(a) knows or believe that they are a beneficiary under the will of the patient, or a recipient in any other way of a financial or other material benefit resulting from the patient's death;

(b) are an owner or operator of any health care facility at which the patient is being treated or any facility in which patient resides;

(c) are directly involved in providing health care services to the patient; or

(d) directly provide personal care to the patient.

The College requires that:

A. Physicians who obtain informed consent for medical assistance in dying must have sufficient knowledge of the patient's condition and circumstances to ensure that:

1. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

2. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and

3. the patient is offered appropriate counseling resources; and

4. the patient fully understands that:

    a. death is the intended result of the pharmaceutical agent(s); and

    b. the potential risks and complications associated with taking the pharmaceutical agent(s).

B. Each physician who obtains informed consent from the patient for medical assistance in dying must:

1. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical condition and the patient's medical decision making capacity; and

2. meet the legal requirements for informed consent, including informing the patient of:

    a. material information which a reasonable person in the patient's position would want to have about medical assistance in dying;

    b. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and

3. meet with the patient separate from family members or others who may influence the patient's decision least once to confirm that his/her decision to terminate his/her life alone at by medical assistance in dying is voluntary and that the patient has:

    a. made the request him/herself thoughtfully; and

    b. a clear and settled intention to end his/her own life by medical assistance in dying after due consideration;

    c. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and

    d. made the decision freely and without coercion or undue influence from family members, health care providers or others.

C. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements for obtaining informed consent.

5. Additional Requirements of the Federal Legislation

The federal legislation also:

(a) requires that physicians who, in providing medical assistance in dying, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;

(b) requires physicians to comply with guidelines established for the completion of certificates of death for patients to whom medical assistance in dying is provided;

(c) creates criminal offences for knowingly failing to comply with the eligibility and safeguard requirements set out in criminal code and destroying documents with the intent to interfere with a patient's access to medical assistance in dying, the assessment of a request for medical assistance in dying or a person seeking an exemption related to medical assistance in dying;

(d) requires physicians to provide a written report in several circumstances related to Medical Assistance in Dying. The reporting requirements are set out under the heading **Reporting and Data Collection** in this policy. A physician who receives a written request for Medical Assistance in Dying is generally required to file a report with the Saskatchewan Health Authority.

6. Specific Requirements of the Prescribing or Administering Physician

In this section "administering physician" refers to a physician who administers pharmaceutical agent(s) for the purpose of terminating the patient's life.

In this section "prescribing physician" refers to a physician who prescribes pharmaceutical agent(s) for the purpose of patient self-administration to terminate the patient's life.

Both prescribing physicians and administering physicians are responsible for confirming that all of the requirements of this policy have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can be only one administering or prescribing physician for each patient.

In this section "self-administration", "administration by the patient" and similar terms include situations where pharmaceutical agent(s) are administered with the assistance of a non-physician at the direction of the patient.

A. The College requires that:

1. an administering physician must have the authorization of the Saskatchewan Health Authority to administer pharmaceutical agents to cause the death of patients where the pharmaceutical agent(s) are administered in a the Saskatchewan Health Authority facility or the College if the pharmaceutical agents(s) are administered elsewhere;

2. a prescribing physician must have the authorization of the College to prescribe pharmaceutical agents to cause the death of patients;

3. an administering or prescribing physician must have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent;

4. a prescribing physician must have appropriate knowledge and technical competence to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to self-administer the pharmaceutical agent(s);

5. an administering physician must be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead; and

6. A prescribing physician must

    a. Personally take possession of the pharmaceutical agents that are intended to bring about the patient's death;

    b. Personally deliver the pharmaceutical agent(s) to the patient at the time and location that are mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);

    c. Be personally present at the time and location that are mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);

    d. Bring the necessary equipment and pharmaceutical agent(s) to cause the death of the patient by intravenous administration at the time and to the location mutually agreed to between the patient and the physician for self-administration of the pharmaceutical agent(s);

    e. Administer pharmaceutical agents by intravenous administration to cause the death of the patient if the self-administration by the patient does not result in the patient's death, and if the patient is incapable of providing instructions, or the patient requests the physician to administer pharmaceutical agents causing death;

    f. remain at the patient's location until the patient's death.

7. A prescribing or administering physician must certify, in writing, that he/she is satisfied on reasonable grounds that all of the following requirements have been met:

    a. The patient is at least 18 years of age;

b. The patient's medical decision making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the *Criminal Code* and this policy;

c. All of the requirements of the *Criminal Code* and this policy in relation to assessing eligibility for medical assistance in dying and obtaining and documenting informed consent have been met; and

8. A prescribing or administering physician must ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the *Criminal Code* and *The Coroner's Act, 1999* in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.

B. **The Coroner's Act, 1999** requires certain deaths to be reported to a coroner. A death from medical assistance in dying is a reportable death and a physician participating in a medical assistance in dying must comply with the requirements of that Act.

Use of Standard Forms

The Government of Saskatchewan established a working group with broad representation to provide recommendations for forms which could be used to assist physicians, nurse practitioners, pharmacists and other health professionals to comply with the legislation, including the reporting requirements which came into effect November 1, 2018.

The College expects that physicians who receive a written request for Medical Assistance in Dying, or who assess patients for eligibility for medical assistance in dying, or who administer or prescribe for medical assistance in dying will utilize the forms that have been developed and follow the protocols contained in those forms.

The forms developed by the working group are attached as appendices to this policy and include the following:

1) First Assessment Form for Physician and Nurse Practitioners
2) Second Assessment Form for Physician and Nurse Practitioners
3) Written Request for Medical Assistance in Dying (MAID)
4) Confirmation of Patient's Consent to Medical Assistance in Dying (MAID)
5) Referral Form – Practitioner Refers or Transfers the Care of a Patient in Response to a Written Request
6) Patient Withdrawal of Request – Death From Another Cause: Physician/Nurse Practitioner Form
7) Form A: Prescription Protocol for Practitioner-Administered Medical Assistance in Dying (Injection)

8) Form B: Prescription Protocol for Practitioner-Administered Medical Assistance in Dying (Oral)

These forms, other than the forms which describe the protocols for prescribing medications for the purpose of Medical Assistance in Dying, are attached as appendices to this policy.

The College will provide the forms which describe the protocols for prescribing medications for the purpose of Medical Assistance in Dying to physicians on request. Those forms are:

1) Form A: Prescription Protocol for Practitioner-Administered Medical Assistance in Dying (Injection)
2) Form B: Prescription Protocol for Practitioner-Administered Medical Assistance in Dying (Oral)

If additional documentation is developed by the working group, it will be made available through the Government of Saskatchewan, the Saskatchewan Health Authority and/or the College of Physicians and Surgeons website.

Reporting and Data Collection

The Government of Canada adopted regulations which came into effect November 1, 2018. Those regulations require physicians to provide a written report in several circumstances related to Medical Assistance in Dying. A physician is required to report if the physician receives a written request for Medical Assistance in Dying and one of the following occurs:

(a) The physician provides Medical Assistance in Dying;

(b) The physician refers a patient to another practitioner or a care coordination service for Medical Assistance in Dying;

(c) The physician assesses a patient and determines the patient is not eligible for Medical Assistance in Dying;

(d) The physician becomes aware that the patient has withdrawn the request;

(e) The physician becomes aware that the patient has died from a cause other than Medical Assistance in Dying.

If a physician is required to report, that report is made to the Saskatchewan Health Authority. The Saskatchewan Health Authority, together with other stakeholders including the Government of Saskatchewan and the College, have approved forms for use by physicians to meet this reporting obligation. Those forms are attached as appendices to this policy.

The Saskatchewan Health Authority has designated the following person to receive the reporting forms:

Michelle Fisher Fax: 1-833-837-9006

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.

First Assessment Form for Physician and Nurse Practitioners

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:

[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.

□ 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.

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.

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 that are accurate)

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)

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):

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 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 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.

Name (last, first)	
Birthdate (YYYY/MM/DD)	Sex ❑ 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)

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):			
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 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 Record of 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).*		

[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 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).*		
I ensured that another physician or nurse practitioner provided a written opinion (**second assessment**) confirming that the patient met all of the criteria. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(e).*		If checked, please indicate whether the practitioner who provided a second opinion (second assessment) was a: □ Physician or □ Nurse practitioner On what date did the other practitioner sign their written opinion (YYYY/MM/DD)
I was satisfied that the other **practitioner and I are independent.** • I am not in a mentoring or supervisory relationship with the other practitioner(s) involved. • 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 other practitioner(s) or patient in any other way that would affect my objectivity. *Relevant subsections of the Criminal Code: 241.2(3)(f) and 241.2(6).*		
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)

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:

Time between medication administration and death:

Section 6: Prescribing or Providing a Substance to the Patient for the Purpose of Self-Administration

Only complete if you prescribed or provided a substance for self-administration

Date of prescribing or providing the substance *(YYYY/MM/DD)* *If you both prescribed and provided the substance, use the date that you prescribed.*	Where was the patient staying when you prescribed or provided 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)[2] □ Private residence □ Other-specify: □ Do not know

Did the patient self-administer the substance (i.e., the substance was ingested)?

□ Yes □ No □ Do not know *(do not answer questions 6a or 6b if you answered "do not know")*

Time between medication administration and death:

[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.

6a. If the patient did self-administer the substance, indicate:	**6b. If the patient did not self-administer the substance, to the best of your knowledge or belief, indicate:**
I confirm that I was present when the patient self-administered the substance. □	Did the patient die of a cause other than MAID? □ Yes □ No □ Do not know **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.
On what date did the patient self-administer the substance? (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.*	
Where did the patient self-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: □ 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.	

Section 7: 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.

Referral Form -
Practitioner Refers or Transfers the Care of a Patient in Response to a Written Request

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)

Referral Form -
Practitioner Refers or Transfers the Care of a Patient in Response to a Written Request

Section 2: Referring or Transferring the Care of a Patient *Only complete this section if you are providing information about a referral or a transfer of care that is the result of a MAID request.*	
Date of referral or transfer of care (YYYY/MM/DD)	Did you complete an eligibility assessment prior to referring the patient or transferring their care? □ Yes □ No **If yes**, was the patient eligible for MAID, in your opinion? □ Yes □ No
Did you refer the patient elsewhere or transfer their care for any of the following reasons (select all that apply): □ Due to policies on MAID of a hospital, residential care facility or palliative care facility where the patient is located □ Assessing or providing MAID is contrary to your conscience or beliefs □ Due to lack of relevant expertise to provide MAID □ Due to patient's request OR □ None of the above	
Supplementary Information (Please include any additional comments on the above information)	

PLEASE NOTE: the 'Referring or Transferring the Care of a Patient' section above is a reporting requirement of the federal government.

*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.

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)

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

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.