Ontario

Ministry of Health

Clinician Aid B
(Primary) "Medical Practitioner" or "Nurse Practitioner" Medical Assistance in Dying Aid

Medical Assistance in Dying means:

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death;
or

(b) 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.

Medical practitioner means a person who is entitled to practise medicine under the laws of the province of Ontario.

Nurse practitioner means a registered nurse in the extended class who, under the laws of the province of Ontario is entitled to:

1) practise as a nurse practitioner – or under an equivalent designation; and

2) autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

A person is considered to have a **grievous and irremediable** medical condition where:

- they have a serious and incurable illness, disease or disability;
- they are in an advanced state of irreversible decline in capability; and,
- 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.

Note: Persons whose sole underlying medical condition is a mental illness, and who otherwise meet all eligibility criteria, are not currently eligible for MAID.
The term mental illness does not include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities.

The use of this aid is voluntary. It is being provided to assist you in maintaining records of requests for medical assistance in dying. Please use this aid if you are a "Medical Practitioner" or "Nurse Practitioner" and a patient is requesting medical assistance in dying and it is your intention to provide medical assistance in dying to the patient. If you are a "preliminary assessor", you can use this aid to provide information about a determination of ineligibility for a person who has made a request for MAID.

For more information related to your professional obligations with respect to medical assistance in dying, please refer to any guidance and/or policies on medical assistance in dying issued by your regulatory college.

Section 1 – Patient Information

Last Name	First Name

Sex at Birth ☐Male ☐Female ☐Person did not consent to provide the information
☐Other (e.g., intersex) (specify) ►

Gender ☐Male ☐Female ☐Person did not consent to provide the information
☐Other (e.g., intersex) (specify) ►

Date of Birth (yyyy/mm/dd)	Health Insurance Number (e.g., OHIP Number) ☐Not Applicable	Version Code

Province or Territory that Issued Health Insurance Number	Postal Code Associated with Patient's Home Address ☐Patient does not have a home address

Person identifies as: ☐First Nations ☐Métis ☐Inuk/Inuit
☐None of the above ☐Person does not know ☐Person did not consent to provide the information

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Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Person affiliates with which racial, ethnic, cultural group (Select all that apply)

☐Caucasian (white) ☐Black ☐Latin American

☐East Asian (Chinese, Korean, Japanese, Taiwanese, etc.) ☐Middle Eastern (Arab, Persian, Lebanese, Turkish, etc.)

☐South-east Asian (Filipino, Thai, Vietnamese, etc.) ☐South Asian (Indian, Pakistani, Bangladeshi, etc.)

☐Another racial, ethnic, or cultural group (specify)

☐Person does not know ☐Person did not consent to provide the information

In the person's opinion, do they have a disability?

☐Yes ☐No ☐Do not know ☐Person did not consent to provide the information

Section 2 – Practitioner and Preliminary Assessor Information

Last Name	First Name

I am a: ☐Medical Practitioner ☐Nurse Practitioner College Registration Number

▼

If you are a Medical Practitioner, what is your primary area of specialty?

☐Anaesthesiology ☐Cardiology ☐Family medicine ☐General internal medicine ☐Geriatric medicine

☐Nephrology ☐Neurology ☐Oncology ☐Palliative medicine ☐Respiratory medicine

☐Other (specify)

Current Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number ext.	Work Email Address

As the (Primary) "Medical Practitioner" or "Nurse Practitioner" for the above named patient, I declare that:

☐I have received the patient's request* for medical assistance in dying.

* A patient's request (verbal or written) may take any form including Clinician Aid A, a text message or an email. It must, however, be more than an inquiry or a request for information about MAID. The request does not have to be in the format required by the *Criminal Code* as a safeguard when MAID is provided (i.e., duly signed, dated and witnessed) to require reporting. If a patient has been referred to you from another clinician or care coordination service, but the request was not put in writing until after the referral, please indicate that the written request was received directly from the patient or other third party (i.e., family).

Date on which person (or authorized third person) made the request (verbal or written) (yyyy/mm/dd)

From whom did the practitioner or preliminary assessor receive the request for assessment for MAID that triggered the reporting requirement?

☐Person directly ☐Another practitioner or preliminary assessor ☐Care coordination service

☐Other (specify)

☐I am independent of the patient, in that I do not know or believe that I am:

- a beneficiary under the will of the patient;
- 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 I provide relating to this request); or
- otherwise connected to the patient in a manner that could affect my objectivity.

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

☐ I am independent of the secondary Medical Practitioner or Nurse Practitioner (who confirms that the patient meets all the eligibility criteria), in that:

- I and the other Medical Practitioner or Nurse Practitioner are not in a mentoring or supervisory relationship with each other;
- I do not know or believe that I am otherwise connected to the other practitioner in a way that could affect my objectivity; and,
- I do not have any actual or potential conflict(s) of interest with the other practitioner.

Please describe any relationship or connection you may have with the secondary Medical Practitioner or Nurse Practitioner

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To the best of your knowledge or belief, before you received the written request for medical assistance in dying, did the patient consult you concerning their health for a reason other than seeking medical assistance in dying?

☐ Yes ☐ No

Has the person previously made a request for MAID?

☐ Yes ☐ No ☐ Do not know

▼

The outcome of that request:

☐ Assessed and found ineligible

☐ Assessed and found eligible but person withdrew request

☐ Assessed and found eligible but considerable time elapsed since the assessment

☐ Request not actioned

☐ Other (specify) ►

Applicable when patient's death is not reasonably foreseeable only

Does either the practitioner or the other assessing practitioner have expertise in the condition that is causing the person's suffering?

☐ Yes ☐ No

Do you have expertise in the condition causing the patient's suffering?

☐ Yes ► Describe your expertise including any relevant credentials

☐ No ► Provide the name of the clinician with expertise consulted with

☐ Not applicable (Patient's death is reasonable foreseeable)

☐ If neither the practitioner or the other assessing practitioner has expertise in the condition that is causing the person's suffering, one of the two assessing practitioners consulted with a medical practitioner who has expertise in the condition

What was the expertise of the practitioner as it relates to the condition that is causing the person's suffering? (Select all the apply)

☐ Cardiology ☐ General internal medicine ☐ Geriatric medicine ☐ Nephrology ☐ Neurology

☐ Oncology ☐ Psychiatry ☐ Pain management ☐ Respiratory medicine

☐ Other (specify) ►

Section 3 – Confirmation of Patient's Eligibility

I declare that:

☐ The patient is 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; (i.e., has a valid OHIP card or proof of other Canadian publicly-funded health insurance – e.g., from another province).

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

☐ The patient is 18 years of age or older.

☐ I am of the opinion that the patient is capable of making decisions with respect to their health.

☐ The patient has a grievous and irremediable medical condition.

☐ The patient has a serious and incurable illness, disease, or disability.

How long has the person had a serious and incurable illness, disease or disability?

☐ Less than 3 months ☐ Between 3 months and less than 1 year ☐ Between 1 – less than 5 years

☐ Between 5 – less than 10 years ☐ Between 10 – less than 20 years ☐ 20 years or more

☐ Do not know

Indicate the serious and incurable illness, disease or disability (Select all that apply)

Cancer	☐ Breast	☐ Colorectal	☐ Hematologic	☐ Lung	☐ Pancreas
	☐ Prostate	☐ Ovary	☐ Other (specify) ▶		
Neuro	☐ Amyotrophic lateral sclerosis		☐ Dementia	☐ Multiple sclerosis	
	☐ Parkinson's Disease		☐ Other (specify) ▶		
Respiratory Disease	☐ Chronic Obstructive Pulmonary Disease			☐ Pulmonary Fibrosis	
	☐ Other (specify) ▶				
Cardio-vascular condition	☐ Atrial Fibrillation		☐ Congestive Heart Failure	☐ Vasculopathy	
	☐ Other (specify) ▶				
Organ Failure	☐ Kidney	☐ Liver	☐ Other (specify) ▶		

☐ Diabetes

☐ Frailty

☐ Autoimmune condition

☐ Chronic Pain

☐ Mental Disorder (excludes neurocognitive/neurodevelopmental conditions)

(specify)

☐ Other condition/co-morbidity (specify)

☐ The patient is in an advanced state of irreversible decline in capability.

What reasons led you to this opinion? (Select all that apply)

☐ Unable to do most or all activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs)

☐ Reduced or minimal oral intake or difficulty swallowing

☐ Dependent on life sustaining treatments (e.g., transfusions, dialysis, feeding tube, O2, bipap)

☐ Significant dependence on aid(s) for interaction/or mobility (e.g., hearing aids, magnifying equipment, speech supports, memory strategies) and/or mobility, or advanced beyond use of these aids

☐ Severe shortness of breath

☐ Persistent extreme fatigue/weakness

☐ Persistent, significant and escalating chronic pain

☐ Cachexia (extreme weight loss and muscle wasting due to severe chronic illness)

☐ Other (specify)

☐ The illness, disease or disability causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Indicate how the person described the nature of their suffering (Select all that apply)

- ☐ Loss of ability to engage in meaningful activities (e.g., physical/social/leisure activities important to the individual)
- ☐ Loss of ability to perform activities of daily living (e.g., bathing, food preparation, finances)
- ☐ Inadequate pain control, or concern about it
- ☐ Loss of dignity
- ☐ Inadequate control of other symptoms, or concern about it
- ☐ Perceived burden on family, friends or caregivers
- ☐ Loss of control of bodily functions
- ☐ Isolation or loneliness
- ☐ Emotional distress/anxiety/fear/existential suffering
- ☐ Loss of independence (e.g., having full or majority of autonomy over one's life)
- ☐ Other (specify)

☐ The patient's sole underlying medical condition is not a mental illness.

☐ I have discussed the following with the patient, and following this discussion the patient provided their informed consent to medical assistance in dying:

- The means that are available to relieve their suffering, including palliative care;
- The probable result of the lethal medication to be prescribed or administered; and,
- Any other information that must be discussed in order for the patient to provide informed consent, as set out in the *Health Care Consent Act*, 1996.

☐ I believe that the patient has made a voluntary request for medical assistance in dying, and I have no reason to believe that the patient does not otherwise meet the eligibility requirements to receive medical assistance in dying.

☐ Yes ► Describe how you assessed the voluntariness of the patient's request and why you are of the opinion the patient made a voluntary request:

- ☐ Consultation with patient
- ☐ Knowledge of the 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
- ☐ Review of medical records
- ☐ Other (specify)

☐ No ► Why you were of the opinion that the request was not voluntary and as a result of external pressure? Specify.

☐ I have ensured that the witness who signed the patient's written request for MAID was independent.

Please describe the process through which you assessed the independence of the witness:

- ☐ Consultation with patient
- ☐ Consultation with other health or social service professionals
- ☐ Consultation with family members or friends
- ☐ Consultation with witness
- ☐ Review of medical records
- ☐ Confirmation of use of a volunteer witness (e.g., Dying with Dignity Canada)
- ☐ Other (specify) ►

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

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*) or the practitioner providing expertise in the case of a Track 2 person)?

☐Yes ☐No

▼

Indicate what type of professional you consulted (Select all that apply)

☐Nurse ☐Oncologist ☐Palliative care specialist ☐Primary care provider

☐Psychiatrist ☐Psychologist ☐Social worker

☐Other health care professionals (specify) ►

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Note: The "Medical Practitioner" or "Nurse Practitioner" must include all relevant information regarding the Patient's eligibility in the Patient's medical records.

Section 4 – Confirmation of Safeguards

Note: The consulting "Medical Practitioner" or "Nurse Practitioner" will complete a separate aid (Clinician Aid C).

If this is a case whereby a practitioner determined that the person met all of the eligibility criteria, but subsequently determined that a safeguard has not been met, indicate which safeguard has not been met and specify the reason for this determination.

Which set of safeguards is the person being considered for?

☐Track 1 – Reasonably foreseeable natural death (RFND) safeguards

☐Track 2 – non-RFND safeguards

☐Do not know (at this time)

As the "Medical Practitioner" or "Nurse Practitioner" for the above named patient, I declare that:

☐The patient has made a written request for medical assistance in dying that was signed and dated by the patient, or an **authorized third person**, before an independent witness, after the patient was informed by me or another physician or nurse practitioner that they have a **grievous and irremediable condition.**

Note: A medical assistance in dying provider, assessor, or where applicable, the consulting practitioner with expertise in the condition causing the person's suffering is not permitted to act as a witness or third-party signer.

☐I informed the patient that they may at any time, and in any manner, withdraw their request.

☐An independent (secondary) medical practitioner or nurse practitioner has provided a written opinion confirming that the patient meets the eligibility requirements for medical assistance in dying.

Is the patient's death reasonably foreseeable?

☐Yes ☐No

Applicable when patient's death is not reasonably foreseeable only

☐The patient has been informed of the means that are available to relieve their suffering, including where appropriate, counselling services, mental health and disability support services, community services and palliative care.

Which means to relieve their suffering were discussed and offered to the person? (Select all that apply)

☐Pharmacological ☐Non-pharmacological (e.g., neuro stimulation, ECT) ☐Counselling

☐Mental health support ☐Disability support ☐Community services – income

☐Community Services – housing ☐Community services – other ☐Health Care services including Palliative care

If necessary, please specify

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

☐ The practitioner confirms that the person was offered consultations with relevant professionals who provide those services or that care.

Indicate how and on what basis the assessing practitioners formed the opinion that the person has given serious consideration to the means to relieve their suffering. (Select all that apply)

- ☐ Consultation with patient
- ☐ Consultation with family/friends
- ☐ Consultation with professional care / medical providers
- ☐ Accepted/attempted multiple treatments appropriate for the condition
- ☐ Previous knowledge of patient
- ☐ Receptive to discussion on available means to relieve suffering
- ☐ Review of medical records
- ☐ Other (specify)

☐ The practitioner confirms that they and the other assessing practitioner discussed with the person the reasonable and available means to relieve the person's suffering.

☐ The practitioner confirms that they and the other assessing practitioner agree that the person has given serious consideration to the reasonable and available means to relieve their suffering.

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Section 5 – Additional Request Details

Note: This section must be completed if the medical or nurse practitioner is providing MAID. This section must also be completed by the provider for cases where the provider is neither the first assessor nor the second assessor.

☐ The First Assessor will not be the MAID Provider.

Did the person receive disability support services?

☐ Yes ☐ No ☐ Do not know

▼

Did the patient receive palliative care?

☐ Yes ☐ No ☐ Do not know

▼

For how long?

☐ Less than 2 weeks ☐ 2 weeks to less than 1 month ☐ 1-6 months ☐ More than 6 months ☐ Do not know

Where did they receive it? (Select all that apply)

☐ Home-based ☐ Hospice care ☐ Hospital-based (in-patient)
☐ Hospital-based outpatient or medical clinic / ambulatory service ☐ Do not know

What were the types of palliative care received? (Select all that apply)

☐ Pain/symptom management ☐ Personal support services (e.g., PSW care) ☐ Volunteer supports
☐ Psychosocial care and/or counselling ☐ Spiritual care and/or counselling ☐ Palliative chemotherapy
☐ Palliative radiation therapy ☐ Physiotherapy ☐ Occupational therapy ☐ Do not know
☐ Other (specify)

If no, to the best of your knowledge or belief, was palliative care accessible to the patient?

☐ Yes ☐ No ☐ Do not know

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Did the patient require disability support services? *

* As defined by Health Canada, 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 ☐Do not know

▼

Did the person receive disability support services?

☐Yes ☐No ☐Do not know

▼

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

What were the services received? (Select all that apply)

☐Aids to support physical mobility i.e., walker, wheelchair, cane, scooter

☐Aids to support audio/visual/communication i.e., hearing aid, large print materials, magnifiers, communication boards, eye gaze technology, write boards

☐Aid to support safety/access/transfers/ADLs – handrails, bath seat, ramps, commode, bed rail, transfer board, lift, adapted utensils

☐Disability income supports – WSIB, CPP-D, ODSP, STD, LTD, insurance settlements

☐Mental health / social support professional services – social work, psychotherapy, counselling, case worker

☐Physical support services – PSW, supervision for personal care, OT/PT, nursing

☐Physiotherapy

☐Other (specify)

☐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

If the patient had difficulty communicating, did you take 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?

☐Yes ☐Not Applicable

▼

Did the person receive disability support services?

☐Independent translation/interpretive services

☐Augmented and alternative communication devices/strategies (e.g., physical gestures, writing boards, eye gaze equipment, communication boards)

☐Additional time

☐Other (specify) ►

Section 6 – Confirmation of a Period of Assessment for the Patient (Only applicable when patient's death is not Reasonably Foreseeable)

This section should be completed by the (primary) "Medical Practitioner" or "Nurse Practitioner" following the approval of eligibility by the (secondary) "Medical Practitioner" or "Nurse Practitioner".

The practitioner ensured that there were at least 90 clear days between the day on which the first assessment of whether the person met the eligibility criteria began and the day on which MAID is provided?

☐Yes ☐No

▼

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

☐ If no, and a shorter period of less than 90 days was considered appropriate in the circumstances, the practitioner ensured that the eligibility assessments were completed, and they and the other assessing practitioner were both of the opinion that the loss of the person's capacity to provide consent to receive MAID was imminent.

Date of First Assessment (yyyy/mm/dd)

Length of Assessment

Date on which the practitioner began their eligibility assessment for MAID or the date the other assessing practitioner began that assessment, whichever is earlier (yyyy/mm/dd)

The number of days from the start of the eligibility assessment (date indicated above) to the latest of these dates:

(a) Date on which the practitioner completed their eligibility assessment;

(b) Date on which the other assessing practitioner completed their eligibility assessment;

(c) Date on which the person has been informed of the means available to relieve their suffering – including, where appropriate, counselling services, mental health and disability support services, community services and palliative care – and has been offered consultations with relevant professionals who provide those services or that care (safeguards 241.2(3.1)(g) of the Code);

(d) Date on which the practitioner and the other assessing practitioner have discussed with the person the reasonable and available means to relieve the person's suffering and both assessing practitioners agree with the person that the person has given serious consideration to those means (safeguards 241.2(3.1) (h) of the Code).

Length of Assessment: ☐ Less than 90 days ☐ 90 to 120 days ☐ 121 to 180 days ☐ 181 to 365 days ☐ 1 to 2 years ☐ More than 2 years

Section 7 – Waiver of Final Consent (Only applicable when patient's death is reasonably foreseeable)

☐ The patient met all eligibility criteria and safeguards, and I have informed the patient they are at risk of losing capacity to provide consent to receive medical assistance in dying prior to the day specified in the arrangement below.

☐ I found it appropriate to discuss the use of a Waiver of Consent with the patient.

The person and I have a written arrangement in place that I would administer a substance to cause the person's death on a specified day.

☐ Yes ☐ No

▼

Did the person consent through the written arrangement to you administering the substance to cause their death on or before the date specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day?

☐ Yes ☐ No

The person lost the capacity to consent to receiving MAID.

☐ Yes ☐ No

▼

▼

☐ The person did not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration.

☐ The substance was administered to the person in accordance with the terms of the arrangement.

Date Waiver of Consent was signed (yyyy/mm/dd)

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Section 8 – Approval Status (To be completed by medical or nurse practitioner only)

Is the patient eligible to access medical assistance in dying?

☐Yes ☐No ► Explain

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Section 9 – Withdrawal of Request

As the (primary) "Medical Practitioner" or "Nurse Practitioner" for the above named patient, I declare that:

Immediately before the providing of medical assistance in dying (For example, before the provision of clinician administered MAID or before the writing of a prescription for a patient self-administered MAID), I gave the patient the opportunity to withdraw their request, and that the patient:

☐Withdrew their Request

▼

If known, what were the person's reasons for withdrawing their request? (Select all that apply)

☐The person accepted the means to relieve their suffering

☐Individuals who the person considers important in their lives (e.g., religious leaders, family, caregivers, or professionals) do not support MAID

☐Upon learning additional information about MAID, the person decided it was not a path they wish to pursue

☐Meeting the needs of a transfer and/or consultation were too cumbersome for the person

☐Other (specify) ►

If the person accepted the means to relieve their suffering which led them to withdraw their request, what means were pursued? (Select all that apply)

☐Pharmacological ☐Non-pharmacological (e.g., neuro stimulation, ECT)

☐Counselling ☐Mental health support ☐Disability support services

☐Community services – income ☐Community services – housing ☐Community services – other

☐Health care services including palliative care

☐Other (specify) ►

☐Provided their express consent to receive medical assistance in dying.

☐Met the statutory criteria for a waiver of final consent (the patient had lost capacity to consent to receiving MAID, the patient did not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration and MAID was administered to the patient in accordance with the terms of the arrangement.).

If the patient had difficulty communicating, did you take 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?

☐Yes ☐Not Applicable

▼

Did the person receive disability support services?

☐Independent translation/interpretive services

☐Augmented and alternative communication devices/strategies (e.g., physical gestures, writing boards, eye gaze equipment, communication boards)

☐Additional time

☐Other (specify) ►

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Section 10 – Provision of Medical Assistance in Dying and Information about Death

As the (primary) “Medical Practitioner” or “Nurse Practitioner” for the above named patient, I declare that I:

☐ Informed the pharmacist or pharmacy technician, before the substance that I prescribed or obtained for the person was dispensed, that the substance was intended for the purpose of providing medical assistance in dying.

☐ Provided the patient with a prescription for a lethal medication, which the patient may self-administer for the purposes of hastening death.

Date (primary) “Medical Practitioner” or “Nurse Practitioner” prescribed the substance (for patient-administered medical assistance in dying) (yyyy/mm/dd)

Did the person receive disability support services?

☐ Hospital (excludes palliative care beds or unit)
☐ Palliative care facility (includes hospital-based palliative care beds, unit or hospice)
☐ Residential care facility (includes long-term care facilities)
☐ Private residence (includes retirement home)
☐ Correctional facility/Prison
☐ Shelter/Group Home
☐ Other (specify) ►
☐ Do not know

(If applicable) Date patient self-administered lethal medication (yyyy/mm/dd)

Did the person self-administer the substance?

☐ Yes ☐ No ☐ Do not know

Did the person receive disability support services?

☐ Hospital (excludes palliative care beds or unit)
☐ Palliative care facility (includes hospital-based palliative care beds, unit or hospice)
☐ Residential care facility (includes long-term care facilities)
☐ Private residence (includes retirement home)
☐ Other (specify) ►
☐ Do not know

Did the self-administration of the substance cause the person's death?

☐ Yes ☐ No ☐ Do not know

Or

☐ Administered a lethal medication to the patient, for the purpose of hastening death.

Date the (primary) “Medical Practitioner” or “Nurse Practitioner” provided the lethal medication (clinician-administered) to the patient (yyyy/mm/dd)

In the case where the administration of the second substance, by the practitioner, was the result of a person not dying after the self-administration, an indication of whether:

☐ Before the person lost the capacity to consent to receiving MAID, the person had entered into a written arrangement with the practitioner (providing that they would be present at the time of self-administration and that they would administer a second substance to cause the person’s death if, after self-administering the first substance, the person did not die within a specified period.

☐ The person self-administered the first substance, did not die within the period specified in the arrangement and lost the capacity to consent to receiving MAID.

☐ The practitioner administered the second substance to the person in accordance with the terms of the arrangement.

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

Was the person transferred to another location for the provision of MAID?

☐Yes ☐No

▼

If known, what were the reasons the person transferred to another location? (Select all that apply)

☐Transfer due to public health recommendations

☐Transfer due to policies of the facility where the person was located

☐Availability/capacity/comfort of practitioners within the facility where the person was located

☐Privileges were not available in a timely manner (or at all) to the practitioners within the facility in which the person was located

☐Person requested a transfer to an alternate location

☐Other (specify) ►

Any complications with the procedure?

☐Yes ☐No

▼

Specify

Type of MAID Medication Administered

Name	Dose	Unit

Did the person register for:

☐Organ donation ☐Tissue donation ☐Body/organ donation to a school of anatomy/research purposes

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Section 11 – Notification of the Coroner of a Medical Assistance in Dying Death

Upon immediately learning of the patient's death due to medical assistance in dying, I declare that:

☐I have given notice of the death to a coroner as required by the *Coroners Act.*

☐I have provided the Office of the Chief Coroner of Ontario with any information about the facts and circumstances relating to the death that are considered necessary to form an opinion about whether the death ought to be investigated.

☐The patient had a natural death before MAID could be provided.

Specify underlying reason

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)

Section 12 – Death as a Result of Other Causes

In the case where a person did not self-administer the substance, has the person died of a cause other than MAID?

☐Yes ☐No ☐Do not know

▼

Date of Death (yyyy/mm/dd) ☐Do not know

An indication of whether the practitioner completed the death certificate in the case where a person died of a cause other than MAID.

☐Yes ☐No

▼

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

What was the immediate cause of death indicated on the death certificate?

What was the underlying cause of death indicated on the death certificate?

If known, what was the underlying reason(s) that led to the person dying of a natural death, before receiving MAID? (Select all that apply)

- ☐ Person was referred or requested MAID too late (i.e., referral time was too short)
- ☐ Person died before both assessments were completed
- ☐ Person was found eligible but died before scheduled MAID provision
- ☐ Person never chose a date to proceed with MAID provision
- ☐ No assessor/provider available/willing
- ☐ Operational issues (i.e., could not be moved to a facility that allowed MAID, medication shortages, bed shortages, health care personnel unavailable)
- ☐ Loss of capacity to consent without a waiver of final consent being completed
- ☐ Lack of pharmacy willing to provide MAID medications
- ☐ Other (specify)
- ☐ Do not know

Signature (Medical or Nurse Practitioner)	Date (yyyy/mm/dd)