Ontario Ministry of Health

Clinician Aid C
(Secondary) "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.

Please complete this voluntary aid (Clinician Aid C) if you have been asked by a "Medical Practitioner" or "Nurse Practitioner" to provide a written opinion confirming that the Patient meets the eligibility criteria to receive medical assistance in dying. You should also include the completed aid in the patient's medical records.

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

☐I am independent of the Patient and the (primary) Medical Practitioner or Nurse Practitioner, 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 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 (other than standard compensation for services I provide relating to this request);
- I do not know or believe that I am otherwise connected to the patient or 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 primary Medical Practitioner or Nurse Practitioner

Applicable when patient's death is not reasonably foreseeable only

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)

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

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).

☐ 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.

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

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.

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)

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

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

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 – 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.

☐I will not be the MAID Provider.

From whom did you receive the 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).

☐Patient directly ☐Another practitioner ☐Care coordination service

☐Another third party (specify) ►

To the best of your knowledge or belief, before you received the 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

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

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

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

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) ►

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

Section 5 – Approval Status (To be completed by medical or nurse practitioner only)

Is the patient eligible to access medical assistance in dying?

☐Yes ☐No ▶ Explain

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)

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