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;
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; and,
- they are being in an advanced state of irreversible decline in capability; and,
- they are experiencing enduring physical or psychological suffering, due to the illness, disease, disability or state of decline, that is intolerable to the person and cannot be relieved in a manner 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. 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

Gender

☐ Male ☐ Female ☐ Other

Date of Birth (yyyy/mm/dd)

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

Date Written Request Received (not date request was signed) * (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

* A patient's written request may take any form including Clinician Aid A, a text message or an e-mail. It must, be more than an inquiry or a request for information about MAID and 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).

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

Section 2 – Practitioner Information

I am a

☐ Medical Practitioner ☐ Nurse Practitioner

College Registration Number

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

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

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

☐ Other – specify: _____

Last Name	First Name

Current Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number ext.	Work E-mail Address

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

☐ I have received the patient's completed and signed patient request for medical assistance in dying.

- Date patient (or authorized third person) signed the patient request: _____

☐ 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.

☐ 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:

_____

Applicable when patient's death is not reasonably foreseeable only:

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

☐ Yes ☐ No ☐ N/A (Patient's death is reasonable foreseeable)

If yes, please describe your expertise including any relevant credentials

If no, please provide the name of the clinician with expertise consulted with:

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

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, meaning that:

The patient has a grievous and irremediable medical condition, meaning that:

- The patient has a serious and incurable illness, disease, or disability;
- The patient is in an advanced state of irreversible decline in capability;
- 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. The patient's sole underlying medical condition is not a mental illness.
- The patient's sole underlying medical condition is not a mental illness.

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

- After being informed of the means that are available to relieve their suffering, including palliative care;
- All possible results including potential risks associated with the lethal medication to be prescribed or administered;
- 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*.

☐ 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.

- Please 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: _____

☐ 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)

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).

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.

☐ 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 – Discuss with patient whether they would like to complete the waiver of final consent form.

☐ No – Ensure Section 2 (Practitioner Information) and Section 6 (Assessment Period) of this form are completed.

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, and being offered consultations with relevant professional who provide those services or that care.

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

Section 5 – Mandatory Reporting under the Federal Medical Assistance in Dying Monitoring Regulations

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.

From whom did you receive the written request for medical assistance in dying? *

☐ Patient directly ☐ Another practitioner ☐ Care coordination service ☐ Another third party – Specify: _____

* A patient's written request may take any form including Clinician Aid A, a text message or an e-mail. 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).

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

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*)?

☐ Yes ☐ No

If yes, indicate what type of professional you consulted (select all that apply):

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

☐ Psychiatrist ☐ Psychologist ☐ Social worker ☐ Speech pathologist

☐ Other health care professionals - specify: _____

Did the patient receive palliative care?

☐ 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? *

☐ Yes ☐ No ☐ Do not know

* 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.

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

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

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".

As the (primary) "Medical Practitioner" or "Nurse Practitioner" for the above named patient, whose natural death is not reasonably foreseeable, I declare that:

☐ There will be at least 90 clear days between the first assessment and the day on which I provide medical assistance in dying;

Or

☐ I and the other Medical Practitioner or Nurse Practitioner are both of the opinion that the patient's loss of their capacity to provide informed consent, is imminent – and therefore I considered the following period of assessment to be appropriate in the circumstances.

- Please specify term in days _____

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

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.

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

The patient and I have a written arrangement in place to waive final consent which was made prior to the day the patient lost capacity to consent to receive medical assistance in dying (if appropriate).

☐ Yes ☐ No

If Yes, did the patient consent to you administering the substance to cause their death if the patient lost their capacity to consent to receive medical assistance in dying on or before the date specified in the arrangement?

☐ Yes ☐ No

Date Waiver of Consent was signed: (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 If 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

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

List manner in which express consent was provided: (i.e., verbal, written):

☐ Did not demonstrate refusal by words, sounds or gestures, nor resisted the administration of the substance.

☐ 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.).

Signature	Date (yyyy/mm/dd)

Section 10 – Provision of Medical Assistance in Dying

As the (primary) "Medical Practitioner" or "Nurse Practitioner" for the above named patient, I declare that 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 medical assistance in dying.

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

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

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

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)

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.

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