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; 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.

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
Gender ☐ Male ☐ Female ☐ Other	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	

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	

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

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

If yes, please describe your expertise including any relevant credentials:

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 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; and
- 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:

- After being informed of 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.

- 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

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

☐ Other – specify: ____________________

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

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

Section 4 – 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.

☐ I 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

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

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

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 5 – 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)