



Medical Assistance in Dying REQUEST FOR MEDICAL ASSISTANCE IN DYING

HLTH 1632 PAGE 1 OF 3

Patient Label

Requestor: submit this form to your medical practitioner or nurse practitioner, or MAiD Care Coordination Service (MCCS). Practitioner: if required, fax or mail a COPY of this form to the applicable health authority MCCS. See bottom of page 3 for the MCCS contact information.

1. REQUESTOR INFORMATION

Form section 1 containing fields for Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Sex at Birth, Preferred Gender, Requestor's Home / Residence Address, City, Postal Code, Phone Number, Medical Diagnosis Relevant to Request for Medical Assistance in Dying, Primary Health Care Provider (Name), Provider Phone Number, Contact Person(s) for MAiD Requests, Preferred Contact Name, Relationship, Contact's Phone Number, and a question about organ donation.

2. ADDITIONAL INFORMATION

Federal regulations require that this information be collected to better understand inequality or disadvantage in relation to MAiD. You may indicate that you do not consent to provide this information. This will not affect your eligibility for MAiD.

Form section 2.1: Do you identify as First Nations, Métis and/or Inuk/Inuit? If Yes (select all that apply): First Nations, Métis, Inuk/Inuit.

Form section 2.2: With which racial, ethnic or cultural group do you identify? (choose all that apply): Black, East Asian, Latin American, Middle Eastern, South East Asian, South Asian, White, Another racial, ethnic or cultural group, Do not know, I do not consent to provide this information.

Form section 2.3: In your opinion, do you have a disability? If Yes, what type(s) of disability do you have? (select all that apply): Seeing, Hearing, Mobility, Flexibility, Dexterity, Pain-related, Learning, Memory, Developmental, Mental health related, Other long term condition, Do not know, I do not consent to provide this information. If Yes, how long have you had your disability? If Yes, how often does your disability limit daily activity?

Form section 2.4: Where is your usual place of residence? If you live in a private residence, who do you live with? Live with family, Live alone, Live with relatives, Live with non-relatives, Other.

Last Name of Requestor	First Name of Requestor	Second Name(s) of Requestor
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3. PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name	First Name	ID Number	Date of Service (YYYY / MM / DD)
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4. MY REQUEST – *A proxy may sign for you if you are physically unable to sign the request, but CANNOT be the same person as Witness on page 3:

I am eligible for health services funded by a government in Canada, or am in the process of completing a waiting period to become eligible.

Yes No → If Yes: BC Medical Services Plan Other, Specify:

By initialing and signing below, I confirm that:

Initials	I request medical assistance in dying. I make this request voluntarily, without pressure from others, and if I am found eligible, I expect to die when the prescribed medication is administered.
Initials	I have been informed by a practitioner that I have an incurable illness, disease or disability.
Initials	I believe that my medical condition is serious and cannot be relieved by any means I accept.
Initials	Where required by law, I understand that my information will be shared with other health professionals directly involved in my care.
Initials	I can and have the right to change my mind and to ask questions at any time.
Initials	I understand that it is my responsibility to seek advice on my life insurance policy.

5. REQUESTOR SIGNATURE (Requestor must sign and date, by hand, in the physical or virtual presence of Independent Witness listed on page 3)

Signature of Requestor	Date Signed (YYYY / MM / DD)	Print Name
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PROXY SIGNATURE (IF APPLICABLE) (Proxy must sign and date, by hand, in the PHYSICAL presence of the Requestor and the physical or virtual presence of Independent Witness listed on page 3)

By signing below as the Proxy on behalf of the Requestor, I confirm that:

- I am at least 18 years of age
- I understand the nature of the request for medical assistance in dying
- I do not know or believe that I am a beneficiary under the will of the person making the request or a recipient in any other way of a financial or other material benefit resulting from the person's death.
- I signed this request for MAiD in the physical presence of the person making the request, on their behalf and under their express direction.

Signature of Proxy	Print Name	Relationship to Requestor	
	Date Signed (YYYY / MM / DD)	Phone Number	
Address	City	Province	Postal Code

See page 3 for Confirmation of Independent Witness and Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms →

Last Name of Requestor	First Name of Requestor	Second Name(s) of Requestor
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6. CONFIRMATION OF INDEPENDENT WITNESS (to be completed by the witness)

By initialing and signing below, I confirm that:

Witness	
Initials	a. I am at least 18 years of age and understand the nature of the request for medical assistance in dying.
Initials	b. The Requestor is personally known to me or has provided proof of identity.
Initials	c. The Requestor (or the Proxy in the presence and at the express direction of the Requestor) signed this request in my presence.
Initials	d. I do not know or believe that I am a beneficiary under the will of the Requestor, or a recipient, in any other way, of a financial or material benefit resulting from the Requestor's death.
Initials	e. I am not an owner or operator of a health care facility where the Requestor is receiving treatment or in which the Requestor resides.
Initials	f. I provide paid health care services or personal care services to the Requestor as part of my primary occupation and I am not the assessor, prescriber or consultant involved in the Requestor's assessment for MAiD.* OR I do not provide health care services or personal care services directly to the Requestor.*

** A witness is still considered independent if they provide health care services or personal care to the Requestor as their primary occupation and are paid to do so, and are not the assessor, prescriber, or consultant involved in the Requestor's assessment for MAiD.*

7. SIGNATURE OF INDEPENDENT WITNESS (Witness must sign and date, by hand, in the physical or virtual presence of the Requestor or Proxy, and on the same date)

Signature of Witness	Print Name	Relationship to Requestor		
	Date Signed (YYYY / MM / DD)	Phone Number		
Address	City	Province	Postal Code	

Please ensure all of the boxes above are completed. To proceed with an assessment of eligibility, submit this form to your physician or nurse practitioner, or contact your health authority's care coordination service for medical assistance in dying (contact information below). Please keep a copy of your request for your records.

Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see:

<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms>

Fraser Health Authority	Phone: 604-587-7878, Fax: 604-523-8855, Email: mccc@fraserhealth.ca https://www.fraserhealth.ca/Service-Directory/Services/end-of-life/medical-assistance-in-dying
Interior Health Authority	Phone: 1-844-469-7073, Fax: 250-469-7066, Email: maid@interiorhealth.ca https://www.interiorhealth.ca/health-and-wellness/palliative-and-end-of-life-care/medical-assistance-in-dying
Northern Health Authority	Phone: 1-888-645-8527, Fax: 250-565-2640, Email: maid@northernhealth.ca https://www.northernhealth.ca/health-topics/medical-assistance-dying-maid
Vancouver Coastal Health Authority	Phone: 1-844-550-5556, Fax: 1-888-865-2941, Email: AssistedDying@vch.ca http://www.vch.ca/assisted-dying
Vancouver Island Health Authority	Phone: 1-877-370-8699, Fax: 250-519-3669, Email: maid@islandhealth.ca https://www.islandhealth.ca/learn-about-health/medical-assistance-dying/medical-assistance-dying
Provincial Health Services Authority	Phone: 1-888-875-3256, Fax: 604-829-2631, Email: maidcco@phsa.ca http://www.phsa.ca/health-info/medical-assistance-in-dying