

ASSESSMENT FOR MEDICAL AID IN DYING

Date:
Time:
Assessor:
Name of Applicant:
Date of Birth:
OHIP No.:
Address:
Phone No.:
Alternate Phone No.:
Assessment No. 1 []
Assessment No. 2 []
If this is the second assessment what was the date of the first assessment?
THOSE PRESENT
1.
2.
3.

POWER OF ATTORNEY FOR HEALTH:

Family: Spouse:

Is he/she aware of the application for MAID? Yes [] No []

Does he/she support it? Yes [] No []

Parents:

Are they aware of the application for MAID? Yes [] No []

Do they support it? Yes [] No []

Comments:

Children: 1.

2.

3.

4.

Are they aware of the application for MAID? Yes [] No []

Do they support it? Yes [] No []

Comments:

Other Family Members (siblings etc):

Are they aware of the application for MAID? Yes [] No []

Do they support it? Yes [] No []

Comments:

Family Physician:

Is he/she aware of the application for MAID? Yes [] No []

Does he/she support it? Yes [] No []

Can I have your permission to contact him/her? Yes [] No []

History of Main Medical Condition:

Associated Medical Conditions:

Treatment/Medication:

Is further treatment an option that is acceptable to you? Yes [] No []

Additional comments:

Are you involved in a palliative care program? Yes [] No []

If NO – why not?

IMPACT OF ILLNESS/SUFFERING

Physically:

Pain:

Fatigue:

Poor Appetite:

Shortness of Breath:

Swallowing Issues:

Side effects from medications/treatments:

Emotionally:

Loss of pleasure:

Sadness/depression:

Fear of the dying process:

Being a burden:

Function:

Ambulation:

Self care:

Independence:

Clinical Frailty Scale:

Palliative Performance Scale:

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

Yes No

The patient has a grievous and irremediable medical condition:

incurable

advanced state of irreversible decline in capacity

Comment:

suffering enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions acceptable to the patient.

Comment:

death has become reasonably foreseeable

Comment:

Is there evidence of coercion? Yes No

Can clinical depression be ruled out as a cause of the request? Yes No

Location preferred for MAID: Home: Other:

Opinion of the Assessor:

This patient meets the requirements of Bill C14 and qualifies for Medical Assistance in Dying

This patient does not meet the requirements of Bill C14

Signed:

Date:

Time: