MEDICAL ASSISTANCE IN DYING (MAID) −
ADVANCED REQUEST: WAIVER OF FINAL CONSENT

MAID Case #:	
First Name:	**Last Name:**
Health Card Number:	**Date of Birth (YYYY/MON/DD):**

Patient Section

Persons whose natural death has become reasonably foreseeable may complete an Advance Request to waive final consent for MAID to take place on a particular date under the following conditions:

- This written arrangement is made with the Physician or Nurse Practitioner who is scheduled to perform the MAID procedure, or by another suitable MAID Provider identified by the MAID Access and Resource Team, should the first clinician be unable to do the procedure on that date.
- This option is available for persons who:
  - have been assessed and approved for MAID, and
  - have indicated their preferred date for their MAID procedure, and
  - were informed by the physician or nurse practitioner of the risk of losing the capacity to consent prior to the specified day.

By checking the boxes and signing below, I confirm that:

❑	I am requesting a MAID procedure on (YYYY/MON/DD): _____
❑	I have been informed by my MAID Provider of the risk of losing capacity to give final consent for my MAID procedure.
❑	I request that my MAID Provider complete my MAID procedure on the date indicated above if I have lost capacity to consent to MAID at that time.
❑	I understand that if, on the date of the MAID procedure, I demonstrate by words, sounds or gestures, purposeful refusal or resistance to the administration of a substance that would cause my death, this Advanced Request for MAID will be invalidated, and the MAID procedure will not be performed. I understand that reflexes and other types of involuntary movements, such as a response to touch or to the insertion of a needle, do not constitute refusal or resistance.
❑	I am aware that if the clinician who has agreed to provide MAID to me is not available on the date of the MAID procedure, the MAID Access and Resource Team will attempt to make alternative arrangements to the best of their ability. In rare instances this may include having the MAID procedure rescheduled, and / or provided by the other assessor involved in my care.
❑	If it has been determined that I have lost capacity prior to the date indicated above, I understand that my Substitute Decision Maker / Delegate (insert name: _____) may act on my behalf, and request that the MAID procedure be completed prior to the date indicated above.

Patient Signature

Print Patient Name	Signature of Patient	Date Signed (YYYY/MON/DD)

If the person requesting MAID is physically unable to sign and date this request, another person (a proxy) may do so in the person's presence, on the person's behalf and under the person's express direction. See the following page.

MEDICAL ASSISTANCE IN DYING (MAID) −
ADVANCED REQUEST: WAIVER OF FINAL CONSENT

MAID Case #:	
First Name:	**Last Name:**
Health Card Number:	**Date of Birth (YYYY/MON/DD):**

Proxy Signature			
❑	I am at least 18 years of age.		
❑	I understand the nature of this person's request for MAID		
❑	I am not a beneficiary under the Will of the person making this request for MAID, or a recipient in any other way of financial or other material benefit resulting from this person's death.		
❑	I am signing this document on behalf of: _____ in their presence and under their express direction.		
Print Proxy Name		Signature of Proxy	Date Signed (YYYY/MON/DD)
Relationship tp Person Requesting MAID			

Physician / Nurse Practitioner Section			
❑	I have advised _____ of the risk of losing capacity to give final consent to MAID.		
❑	_____ has requested a MAID Procedure on (YYYY/MON/DD): _____ and I have agreed to provide MAID, even if they have lost capacity to consent to MAID.		
❑	If I am not available to provide MAID on the date noted above I will work with the MAID Access and Resource Team and attempt to make alternative arrangements to the best of our ability. In rare instances this may include having MAID on a different date, and / or provided by the other assessor involved in the care of this patient.		
Physician / Nurse Practitioner Signature			
Print Name of Health Care Practitioner		Signature of Health Care Practitioner	Date Signed (YYYY/MON/DD)

NSMAIDARWFC