MEDICAL ASSISTANCE IN DYING (MAiD)
PATIENT REQUEST AND CONSENT - REASONABLY FORESEEABLE NATURAL DEATH (RFND)

(Both pages must be completed)

When complete, FAX both pages to the MAiD office at 902-454-0379 or scan and email to MAiD@nshealth.ca

Patient Name:	**Case Number:**
Health Card Number:	**Date of Birth (YYYY/MON/DD):**

PATIENT REQUEST SECTION:

MAiD requires a written request which must be signed and dated in front of an independent witness. Another person (Proxy) may sign for the patient, if they are unable to sign and date the request. By signing below, I, "the Patient", confirm that:

- I am making a request for MAiD of my own free will, without any influence or pressure from others.
- I am aware I will be assessed by a minimum of two independent medical doctors and/or nurse practitioners to confirm I meet all the eligibility criteria for MAiD.
- I understand that MAiD involves a medical doctor/nurse practitioner prescribing and administering medication that will result in my death.
- I give permission for my medical records to be reviewed by the medical doctors and/or nurse practitioners and care team reviewing my eligibility for MAiD.
- I understand that MAiD documents will be retained for the purpose of monitoring MAiD processes.
- I am aware that I may, at any time, in any manner, withdraw my request for MAiD.

INFORMED CONSENT SECTION: (To be completed only AFTER the first MAiD eligibility assessment):

By signing below, I, "the Patient", confirm that:

- I believe I am fully informed with respect to the medical condition which has led me to request MAiD, including its nature, expected outcome, treatment options available, and potential complications.
- My medical condition causes me enduring suffering that is intolerable to me, which cannot be relieved by any treatment that I consider acceptable.
- I have been informed by a medical doctor/nurse practitioner about the options available to help relieve my suffering, including palliative care.
- I understand that the purpose and goal of MAiD is to bring about my death, and the risks of proceeding with MAiD have been explained to me.
- I am aware that I will be asked to provide consent again immediately before MAiD is provided unless alternative arrangements have been made.
- After providing my final consent to have MAiD, I authorize my MAiD Provider to administer intravenous medications that will bring about my death.
- My questions have been answered in a way that was understandable to me.
- I agree to the involvement of pharmacist(s), nurse(s), assistants or associates or other health professionals as may be appropriate for the purpose of MAiD, including a community nurse who may be asked to insert intravenous lines.
- I Consent for the MAiD team to disclose my involvement in the MAiD program/process with family physician/primary care provider.

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

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PROXY SECTION (NOTE: A Proxy signature allows the Patient to delegate their signing right to another party (or Proxy signer). This area to be signed ONLY if patient is unable to sign)

By signing below, I, "the Proxy", confirm that:

- I am at least 18 years of age and understand the nature of the Patient's request for MAiD.
- I am not a beneficiary (will not benefit) under the Will of the Patient's 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 the person named above in their presence and at their request.

Print Proxy Name	**Signature of Proxy**	**Date** (YYYY/MON/DD)

WITNESS SECTION:

By signing below, I, "the Witness", confirm that:

- I am at least 18 years of age, and I have been requested to provide written confirmation that I witnessed the signature of the person making this request for MAiD.
- I am not a beneficiary (will not benefit) under the Will of the Patient 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 not an owner or operator of the health care facility where the person making this request for MAiD resides (lives) or is receiving treatment.
- The person making this request for MAiD (or their proxy, in the presence and at the express direction of the patient) signed this request for MAiD in my presence.
- I am not a physician or nurse practitioner that has provided, or will provide, assessment of eligibility for MAiD for the person making this request.

Print Name of Witness	**Signature of Witness**	**Date** (YYYY/MON/DD)

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