MEDICAL ASSISTANCE IN DYING (MAiD) - PROVISION DOCUMENTATION

Patient Name:	**HCN:**	**DOB** (YYYY/MON/DD):

Provision Location:	❑ Private Residence	❑ Nursing Home/LTC Facility
	❑ Hospital/NS Health Facility	❑ Other

Health Care Providers Present:	
Name	**Designation**
Family/Friends Present:	

Pre-Provision Requirements:	
The First and Second assessments have been completed and agree that the patient meets MAiD eligibility criteria.	❑ **Yes**
The appropriate *MAiD Patient Request and Consent Form* has been signed and dated, including the signature of one independent witness: Dated (YYYY/MON/DD):	❑ **Yes**
Immediately prior to providing MAiD, the patient was given the opportunity to withdraw their request for and consent to MAiD, or *Waiver of Final Consent* was signed and dated: Dated (YYYY/MON/DD):	❑ **Yes**
If Non-Reasonably Foreseeable Natural Death (Non-RFND), do you or the other assessor have expertise in the condition causing the person's suffering?	❑ **Yes** ❑ **No** ❑ **N/A**
If Non-RFND, was a specialty consultation required for this case? ***If Yes,*** indicate the specialty consulted:	❑ **Yes** ❑ **No** ❑ **N/A**
If Non-RFND, was the 90-day waiting period completed?	❑ **Yes** ❑ **No** ❑ **N/A**
If Non-RFND, was the waiting period shortened because the patient was at risk of losing capacity?	❑ **Yes** ❑ **No** ❑ **N/A**

Provision Details - Intravenous Access:
IV Inserted in advance (or PICC Line/Port-a-Cath Accessed): ❑ Yes By: _____
IV Inserted by Provider: ❑ Yes **Site 1:** _____ Size _____ G / **Site 2:** _____ Size _____ G ***OR*** PICC Line/Port-a-Cath Accessed by Provider: ❑ Yes
❑ Saline lock only ***OR*** ❑ Solution _____ at _____ mL/h Time started (HH:MM): _____
IV site used for provision: _____

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Waiver of Final Consent:	
Was a *Waiver of Final Consent* form **completed** by this patient?	❑ **Yes** ❑ **No**
For those who completed a *Waiver of Final Consent*, **was it implemented** (i.e., the person lost capacity and was not able to provide final consent immediately before MAiD was provided)?	❑ **Yes** ❑ **No** ❑ **N/A**

Medications Administered:

Time (HH:MM)	**Medication**	**Dose**	**Route**	**Signature**

Death Details:

Date (YYYY/MON/DD):	Time of Death (HH:MM):	Death Pronounced by:
Death Certificate completed **(in blue pen)**: ❑ Yes		
Plan for body retrieval discussed with family and care team: ❑ Yes		
Comments:		
NB: It is the responsibility of the providing clinician to complete the Health Canada MAiD Portal.		

MAiD Provider Details:

Attending Physician/Nurse Practitioner (print)	**Attending Physician/Nurse Practitioner (sign)**
License Number:	Date (YYYY/MON/DD): _____ Time (HH:MM): _____