Alberta

Record of Request for Medical Assistance in Dying

Record of Request form for Medical Assistance in Dying: Patient Instructions

If you have questions or concerns about how to complete the Record of Request form for Medical Assistance in Dying, contact your doctor or nurse practitioner (NP), or contact the Alberta Health Services (AHS) Care Coordination Service at: MAID.CareTeam@ahs.ca or through Health Link at 811.

This form is revised periodically. To ensure that you are using the most current version, please refer to: https://cfr.forms.gov.ab.ca/Form/HSP11175.pdf

Filling out this form is one step in the process of contemplating and requesting medical assistance in dying. At any point in the overall process you may choose to withdraw.

This form assists with ensuring that legal requirements are met before medical assistance in dying is provided. By providing a signed, dated and witnessed request, you are declaring that you understand clearly the request you are making and that you are making this request voluntarily and free of duress or coercion.

When you fill out this Record of Request form, this is not your final chance to decide whether you want to receive the service of medical assistance in dying. That choice will remain yours throughout the process. You will be asked to give your express informed consent immediately before receiving medical assistance in dying.

A. Patient Information Section

In this section, you are making a request for medical assistance in dying. Please initial in each box next to each statement on pages 1 and 2, and sign your name on page 2. If any statement does not apply to your situation, do not initial the corresponding box.

Important: You must initial and sign in the presence of the independent witnesses (see the Declaration of Independent Witnesses section for more details).

If you are physically unable to place your initials and signature on the Record of Request form you may have someone initial and sign as a proxy on your behalf. The proxy must initial and sign the form in your presence and in the presence of the independent witnesses (see the Declaration of Independent Witnesses section for more details).

Important: The Record of Request form is not complete until either you (or your proxy) have signed it in the presence of two independent witnesses, as required by law.

What is a "Proxy"?

A proxy is a person who signs this document on your behalf, if you are unable to sign it. The proxy is not an alternate decision maker and is only authorized to initial and sign this document on your behalf if you are physically unable to initial and sign the request and you give express direction to the proxy to do so.

The proxy must initial the box next to each statement on pages 1 and 2 and sign his or her name at the middle of page 2. The proxy must also complete the Declaration of Proxy section and sign his or her name on page 3.

Important: The person acting as your proxy cannot be one of the independent witnesses.

B. Declaration of Independent Witnesses

In this section, two independent witnesses must verify each statement on page 4 by initialing the corresponding boxes and signing their names at the bottom of page 4. All boxes must be completed. If a witness does not meet all the criteria, a different witness must be obtained.

Important: Each independent witness must witness you (or your proxy) initial and sign the Record of Request form. Each independent witness must also initial each box on page 4. They are not permitted to use checkmarks.

The two independent witnesses do not have to be present at the same time. If both independent witnesses are not available at the same time, you or your proxy will have to sign the Record of Request form in the presence of each witness. This will result in your signature (or your proxy's signature) appearing twice on the Record of Request form.

After completing this Record of Request form, you remain free to change your mind at any point regarding medical assistance in dying. You may withdraw your request at any time by indicating your decision to any attending practitioner by whatever means of communication.

Who can be an Independent Witness?

The two witnesses must be independent of you as described below. Each independent witness must initial the box corresponding to each statement to verify all of the following information:

- the independent witness is at least 18 years of age;
- the independent witness understands the nature of the request;
- you are personally known to the independent witness or have provided proof of identity;
- you or your proxy signed the request in the independent witness' presence;
- the independent witness does not know or believe he or she is a beneficiary under your will or a recipient of financial or material benefit resulting from your death;
- the independent witness is not the owner or operator of a health care facility where you are receiving treatment or a facility where you reside;
- the independent witness is not directly involved in providing health care services to you; and
- the independent witness does not directly provide personal care to you.

Example 1: If the independent witnesses are both present at the same time when you or your proxy sign:

Print Name	Date yyyy-mm-dd	Signature of Patient / Proxy	Date yyyy-mm-dd	Signature of Independent Witness
Jane Doe	2017-01-01	*Jane Doe*	2017-01-01	*Mary Witness* (#1)
			2017-01-01	*John Witness* (#2)

Example 2: If the independent witnesses are not both present at the same time when you or your proxy sign:

Print Name	Date yyyy-mm-dd	Signature of Patient / Proxy	Date yyyy-mm-dd	Signature of Independent Witness
Jane Doe	2017-01-01	*Jane Doe*	2017-01-01	*Mary Witness* (#1)
Jane Doe	2017-01-03	*Jane Doe*	2017-01-03	*John Witness* (#2)

How is the Period of Reflection Determined?

This period of reflection is at least 10 clear days (i.e., at least 10 full days) from the date that the Record of Request is signed. Under exceptional circumstances, the practitioner administering or providing for self-administration of medical assistance in dying and the practitioner providing an independent opinion may agree to shorten the period of reflection because your death, or the loss of your capacity to provide informed consent, is imminent.

In Example 1, the period of reflection would start on January 2, 2017. In Example 2, the period of reflection would start on January 4, 2017.

Where does the Completed Record of Request form go?

On completing this Record of Request form, you may choose to either send or take the form to your doctor or NP, if they are willing to help, who can submit the form to the AHS Care Coordination Service on your behalf. It will be your doctor or NP's responsibility to assist you with the next steps.

If your doctor or NP has advised you that they will not be participating in your request for medical assistance in dying, you can send the Record of Request form to the AHS Care Coordination Service using the numbers or address provided below.

You can also choose to send a copy of the completed form yourself by fax at these numbers or by mail at this address:

- Edmonton & North: 780-641-9123
- Calgary & Central: 403-592-4264
- South: 403-592-4265
- Provincial Medical Assistance in Dying Office
  6th Floor, 10101 Southport RD SW
  Calgary AB T2W 3N2

If you require further assistance, the AHS Care Coordination Service may also be reached by email at MAID.CareTeam@ahs.ca or through Health Link at 811.

After completing this Record of Request form, you remain free to change your mind at any point regarding medical assistance in dying. You may withdraw your request at any time by indicating your decision to any attending practitioner by whatever means of communication.

Attention: Doctors and Nurse Practitioners (NP's)

- The original Record of Request form should be placed in the patient's health care record.
- The patient should keep a copy of the Record of Request form for their personal records.
- All providing practitioners (doctors and NP's) are required to send a copy of the completed Record of Request form (upon the patient's request), including Part A Patient Information and Part B Declaration of Independent Witnesses, to the Medical Assistance in Dying Regulatory Review Committee c/o the Chair of the Regulatory Review Committee by fax at the below numbers or by mail at the below address:
  - Edmonton & North: 780-641-9123
  - Calgary & Central: 403-592-4264
  - South: 403-592-4265
  - Provincial Medical Assistance in Dying Office
    6th Floor, 10101 Southport RD SW
    Calgary AB T2W 3N2

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Record of Request for Medical Assistance in Dying

This information is collected under the authority of sections 20 and 21 of the *Health Information Act*, O.C. 142/2016 and O.C. 320/2016, for the purpose of confirming that the requirements of standards of practice and legislation applicable to medical assistance in dying are met and for the purposes set out in section 27(1)(g), 27(2)(a), (b) and (d) of the *Health Information Act*. This information will be provided to the Medical Assistance in Dying Regulatory Review Committee. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act*. If you have any questions about the collection of this information, please contact a medical assistance in dying policy analyst at Alberta Health, PO Box 1360 Station Main, Edmonton, AB T5J 2N3 or toll-free in Alberta at 310-0000 then 780-427-8089, or by email at hiahelpdesk@gov.ab.ca

A. Patient Information

Last Name	First Name	Middle Name (if applicable)

Date of Birth: Year ____ Month ____ Day ____

Gender: Select "X" if you do not identify as male or female. ○ Male ○ Female ○ 'X'

Personal Health Number (PHN) ____

I, ______________________ (print full name), am at least 18 years of age and I request medical assistance in dying. — Patient / Proxy **Initial** ____

I understand that I have the right to withdraw my request at any time and in any manner. — Patient / Proxy **Initial** ____

I am eligible for insured health services funded by a government in Canada or would be eligible except for a minimum period of residence or waiting period (For example, I have a valid Alberta personal health card or proof of other publicly-funded health insurance from another province or territory). — Patient / Proxy **Initial** ____

I believe, and a medical practitioner or a nurse practitioner has informed me, that I have a grievous and irremediable medical condition and that all of the following apply: — Patient / Proxy **Initial** ____

- I have a serious and incurable illness, disease or disability;
- I am in an advanced state of irreversible decline in capability;
- my illness, disease or disability or state of decline causes me enduring physical or psychological suffering that is intolerable to me and cannot be relieved under conditions that I consider acceptable; and
- my natural death has become reasonably foreseeable, taking into account all of my medical circumstances.

Patient or Providing practitioner: please send a copy of this form to the Medical Assistance in Dying Regulatory Review Committee c/o the Chair of the Regulatory Review Committee by fax at the below numbers or by mail at the below address:
Edmonton & North: 780-641-9123
Calgary & Central: 403-592-4264
South: 403-592-4265
Provincial Medical Assistance in Dying Office, 6th Floor, 10101 Southport RD SW, Calgary AB T2W 3N2

	Patient / Proxy Initial
I request that a medical practitioner or a nurse practitioner either prescribe a substance that I may self-administer, or administer a substance to me, that will cause my death.	
My request for medical assistance in dying is voluntary and, in particular, is not made as a result of external pressure.	
I expect to die when the substance to be prescribed is administered.	
I understand that immediately before being provided medical assistance in dying, I will be asked to give my express informed consent to receive medical assistance in dying.	
I understand that medical assistance in dying cannot be provided until 10 clear days have passed from the date of this request, unless the providing practitioner and an independent practitioner who assesses my eligibility for medical assistance in dying are both of the opinion that my death or the loss of my capacity to provide informed consent is imminent.	
I understand that by requesting the provision of medical assistance in dying, my health information will be collected, used and disclosed to the federal Minister of Health for the purpose of monitoring medical assistance in dying.	

Patient Signature

Print Name of Patient (Proxy) Date yyyy-mm-dd

Signature of Patient (Proxy) Date yyyy-mm-dd Signature of Independent Witness #1

Print Name of Patient (Proxy) Date yyyy-mm-dd

Signature of Patient (Proxy) Date yyyy-mm-dd Signature of Independent Witness #2

To be completed by a proxy only when the conditions for a proxy are met.

Patient or Providing practitioner: please send a copy of this form to the Medical Assistance in Dying Regulatory Review Committee c/o the Chair of the Regulatory Review Committee by fax at the below numbers or by mail at the below address:
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Last updated: July 5, 2019

A proxy may sign for you if you are physically unable to sign the request. The proxy cannot be the same person as a witness. The proxy must meet the requirements set out in the Declaration of Proxy.

Declaration of Proxy

By initialing and signing below, I declare that:

	Proxy Initial
1. I am at least 18 years of age.	
2. I understand the nature of the request for medical assistance in dying.	
3. 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.	
4. I signed this request for medical assistance in dying in the presence of the person making the request, on his or her behalf and under his or her express direction.	

Mailing Address of the Proxy	City/Town	Province	Postal Code	Telephone Number

Print Name

Date yyyy-mm-dd

Signature of Proxy

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B. Declaration of Independent Witnesses

By *initialing* and *signing* below, I declare that:

Declaration	Initial: Witness 1	Initial: Witness 2
1. I am at least 18 years of age.		
2. I understand the nature of the request for medical assistance in dying.		
3. The patient is personally known to me or has provided proof of identity.		
4. The patient signed this request in my presence, on the date indicated that follows the patient's signature; or if the patient was unable to do so, the patient's proxy signed this request on the patient's behalf in my presence and in the presence of the patient and under the patient's express direction, on the date indicated that follows the proxy's signature.		
5. I do not know or believe that I am a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death.		
6. I am not an owner or operator of a health care facility in which the patient is receiving treatment or of a facility in which the patient resides.		
7. I am not directly involved in providing health care services to the patient.		
8. I do not directly provide personal care to the patient.		

Witness Signatures

Print Name of Independent Witness #1 | Mailing Address | City or Town

Province/Territory | Postal Code | Telephone Number | Date Signed yyyy-mm-dd | Signature of Independent Witness #1

Print Name of Independent Witness #2 | Mailing Address | City or Town

Province/Territory | Postal Code | Telephone Number | Date Signed yyyy-mm-dd | Signature of Independent Witness #2

Patient or Providing practitioner: please send a copy of this form to the Medical Assistance in Dying Regulatory Review Committee c/o the Chair of the Regulatory Review Committee by fax at the below numbers or by mail at the below address:
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