New Nouveau Brunswick

Label

Medical Assistance In Dying (MAID) Patient Request

Patient Information

First Name:_____Middle Name(s)_____Surname:_____

Date of Birth: _____(example: May 2, 2016) Age: _____ Medical Record Number:_____ Medicare: _____

Telephone: (Home)_____ (Cell) _____(Work)_____

Family Physician/Nurse Practitioner: _____

Diagnosis: _____

Patient's Statement

I am making a voluntary request for medical assistance in dying. This request is made without external pressure to do so.

I am suffering from a grievous and irremediable medical condition that is causing me enduring and intolerable suffering that cannot be relieved by any means acceptable to me.

I am in an advanced state of irreversible decline in capability and my natural death has become reasonably foreseeable.

I request that I be assessed by a physician/nurse practioner to determine if I meet the criteria to receive medical assistance in dying, or be referred to another physician/nurse practitioner for this initial assessment to occur.

I understand that my request must be reviewed a second time by an independent physician or nurse practitioner confirming that I have met all the eligibility criteria for requesting medical assistance in dying.

I understand that medical assistance in dying can involve a physician/nurse practitioner prescribing medication that I may self-administer or the physician/nurse practitioner prescribing and administering the medication.

I understand that medical assistance in dying can occur in a designated New Brunswick facility or within my home.

I understand that there will be at least 10 clear days, a waiting period between the date when this request is signed by me and the day on which medical assistance in dying can be provided as determined by assessment of eligibility.

I give permission for my medical records to be reviewed by the physicians/nurse practitioners and care team reviewing my eligibility for medical assistance in dying. I understand that my documents will be retained for the purpose of monitoring medical assistance in dying.

I understand that I have the right to rescind this request at any time.

_____	_____	_____
Name of Patient (Print)	**Signature of Patient**	**Date (example: May 2, 2016)**
_____	_____	_____
Name of Person* (Print)	**Signature of Person***	**Date (example: May 2, 2016)**

***If the patient is physically unable to sign the request, a competent adult who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are 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 that person's death may do so in the patient's presence, on the patient's behalf and under the patient's express direction.**

Declaration of Independent Witnesses

Witness 1

❑ I am an independent witness**

❑ I am at least 18 years of age

❑ I declare this patient is making a voluntary request for medical assistance in dying without external pressure to do so.

_____	_____	_____
Name of Witness 1 (Print)	**Signature of Witness**	**Date (example: May 2, 2016)**

Witness 2

❑ I am an independent witness**

❑ I am at least 18 years of age

❑ I declare this patient is making a voluntary request for medical assistance in dying without external pressure to do so.

_____	_____	_____
Name of Witness 2 (Print)	**Signature of Witness**	**Date (example: May 2, 2016)**

** An independent witness means a person who understands the nature of the request for medical assistance in dying; will not benefit under the will of the person making the request; is not a recipient of a financial or material benefit resulting from the person's death; is not an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides; and is not directly involved in providing healthcare or personal care services to the patient.

10750–08/2016