Alberta Health Services

Record of Request for Medical Assistance in Dying (MAID)

Completing this form is one step in the process of contemplating and requesting medical assistance in dying.

This form must be printed and signed in front of an independent witness.

Please read this form carefully prior to completing and if you have questions or concerns about how to complete the Record of Request for Medical Assistance in Dying form, 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 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. At any point in the process, you may choose to withdraw.

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:

by fax *(choose one)*
- Edmonton & North: 780-641-9123
- Calgary & Central: 403-592-4264
- South: 403-592-4265

or by mail: Provincial Medical Assistance in Dying Office
6th Floor, 10101 Southport RD SW
Calgary AB T2W 3N2

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

A. Patient Demographics

Last Name	First Name	Middle Name

Sex at Birth	Date of Birth *(dd-Mon-yyyy)*
☐ Male ☐ Female ☐ Other *(e.g. intersex)*, specify _____	
Gender Identity ☐ Male ☐ Female ☐ Other *(specify)* _____ ☐ I do not consent to provide this information	Personal Health Number (PHN)

2. Patient Contact Information

Home Address			
City	Province	Postal Code	Phone

The collection of your health and personal information on this form (including your Personal Health Number) is legally authorized by sections 20(b), 21(a) and 27(a) of the Health Information Act (Alberta) and section 33 (c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for responding to your request. If you have any questions about the collection of your personal information as provided on this form, please contact the Medical Assistance in Dying Care Coordination Services by emailing maid.careteam@ahs.ca, through Health Link at 811, or sending your questions in writing by prepaid mail addressed to the attention of Provincial Medical Assistance in Dying Office 6th Floor, 10101 Southport Road SW Calgary, AB T2W 3N2.

C. Patient Request	
By initialing and signing below, I confirm that:	**Patient Initial** *(or Proxy Initial if required)*
I am at least 18 years of age and I request medical assistance in dying.	
I understand that I have the right to withdraw my request at any time and in any manner.	
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.	
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: • I have a serious and incurable illness, disease or disability; • I am in an advanced state of irreversible decline in capability; and • 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.	
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 if I have been or am informed by a medical practitioner or a nurse practitioner that my natural death is not reasonably foreseeable: • then medical assistance in dying cannot be provided to me until at least 90 clear days have passed from the day on which the first assessment to determine my eligibility for medical assistance in dying began, • unless, the providing practitioner and an independent practitioner who assesses my eligibility for medical assistance in dying are both of the opinion that loss of my capacity to provide consent to receive medical assistance in dying is imminent.	
I understand that requesting medical assistance in dying will require my health information to be collected, used and disclosed to the Federal Minister of Health in accordance with legislation.	

Patient Signature *(must be signed in the presence of the independent witness listed below)*		
Name of Patient *(print)*	Signature of Patient *(or Proxy if required)*	Date *(dd-Mon-yyyy)*
Name of Independent Witness *(print)*	Signature of Independent Witness	

If you have personally completed and signed page 2, please proceed to page 4.

Otherwise, 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.

D. Declaration of Proxy

	Proxy Initial
I am at least 18 years of age.	
I am completing this request on behalf of the Patient, so that they may request access to medical assistance in dying. Name of Patient _____	
I understand the nature of the request for medical assistance in dying.	
To my knowledge I am not 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.	
I completed and 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.	

Signature of Proxy

Name of Proxy *(print)*	Signature of Proxy	Date *(dd-Mon-yyyy)*
Mailing Address		Phone
City	Province	Postal Code

D. Declaration of Independent Witness *(see Frequently Asked Questions about Witnessing the Record of Request for Medical Assistance in Dying (alberta-healthservices.ca) for general information and guidelines for witnessing a Record of Request)*	
	Witness Initial
I am at least 18 years of age.	
I understand the nature of the request for medical assistance in dying.	
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.	
To my knowledge I am not 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.	
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.	
I am not the medical practitioner or nurse practitioner involved in the assessment for or who will provide medical assistance in dying to the patient.	

Signature of Independent Witness		
Name of Independent Witness *(print)*	Signature of Witness	Date *(dd-Mon-yyyy)*
Mailing Address		Phone
City	Province	Postal Code

The collection of your personal information on this form is legally authorized by section 33 (c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for responding to this request. If you have any questions about the collection of your personal information as provided on this form, please contact the Medical Assistance in Dying Care Coordination Services by emailing maid.careteam@ahs.ca, through Health Link at 811, or sending your questions in writing by prepaid mail addressed to the attention of Provincial Medical Assistance in Dying 6th Floor, 10101 Southport Road SW Calgary, AB T2W 3N2.

Additional Information

To better understand inequality or disadvantage in relation to medical assistance in dying, Federal regulations gives AHS the authority to collect the information, but it is not mandatory.
You may indicate that you do not consent to provide this information. This will not affect your eligibility for medical assistance in dying.

What is your usual place of residence?

- ☐ Hospital *(excludes palliative care beds or unit)*
- ☐ Palliative care facility *(includes hospital-based palliative care beds, unit or hospice)*
- ☐ Residential care facility *(includes long term care facilities)*
- ☐ Private residence *(includes retirement home)*
- ☐ Correctional facility/Prison
- ☐ Shelter/Group home
- ☐ Other *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information

If your usual place of residence is a private residence, what is your living arrangement?

- ☐ Living with family *(partner, children, parents)*
- ☐ Living with relatives
- ☐ Other *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information
- ☐ Living alone
- ☐ Living with non-relatives

Do you identify as First Nations, Métis and/or Inuk/Inuit?

- ☐ Yes *(if yes, please specify)*
  - ☐ First Nations ☐ Métis ☐ Inuk/Inuit
- ☐ No
- ☐ Do not know
- ☐ I do not consent to provide this information

Which racial, ethnic or cultural group best describes you? *(choose all that apply)*

- ☐ Black
- ☐ Caucasian *(white)*
- ☐ East Asian *(Chinese, Korean, Japanese, Taiwanese, etc)*
- ☐ Latin American
- ☐ Middle Eastern *(Arab, Persian, Lebanese, Turkish, etc)*
- ☐ South-east Asian *(Filipino, Thai, Vietnamese, etc)*
- ☐ South Asian *(Indian, Pakistani, Bangladeshi, etc)*
- ☐ Other racial, ethnic or cultural group *(specify)* _____
- ☐ Do not know
- ☐ I do not consent to provide this information

In your opinion, do you have a disability?

- ☐ Yes *(If yes, specify disability)* _____
- ☐ No
- ☐ Do not know
- ☐ I do not consent to provide this information