

Date:

TO:	
Name:	Office of the Chief Medical Examiner (Calgary)
Fax:	780-643-7057 or 403-297-8134
Phone:	403-297-8123

Fax	Cover	Sheet
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Pages: ____(including cover sheet)

FROM:		
Name:		
Fax:		
Phone:		

Re: Medical Assistance in Dying Documentation / Checklist

- □ Record of Request for Medical Assistance in Dying
- Providing Practitioner Record for Medical Assistance in Dying
- □ Consent to Treatment
- □ Record of Medication Administration
- □ Waiver of Final Consent (if applicable)
- □ Reporting should be sent to **<u>both</u>** the ME's Office and MAID Reporting

MESSAGE:

Confidential: This communication is intended only for the individual or institution to which it is addressed and should not be distributed, copied, or disclosed to anyone else. The document(s) in this communication may contain personal, confidential, or privileged information, which may be subject to the Freedom of Information and Protection of Privacy Act, the Health Act and other legislation. If you have received this communication in error, please notify the sender immediately. Thank you for your cooperation and assistance.