Health PEI

REQUEST FOR MEDICAL ASSISTANCE IN DYING

[PATIENT IDENTIFICATION LABEL]

1. REQUESTOR INFORMATION

Last Name	First Name	Second Name(s)
Personal Health Number (PHN)	Birthdate (YYYY/MM/DD)	Phone Number
Address	City	Postal Code

Medical Diagnosis Relevant to Request for Medical Assistance in Dying

Contact Person for MAiD Requests ☐ Myself and/or ☐ Preferred Contact	Preferred Contact Name	Relationship	Phone Number

2. ADDITIONAL INFORMATION

Federal regulations require that the following questions be asked to help form statistics on who is requesting MAiD in Canada. ***This information is voluntary and for statistics purposes only, and is not used as part of your MAiD evaluation****. If you choose not to answer, this will not affect your eligibility for MAiD.*

Do you identify as First Nations, Metis, and/or Inuk/Inuit?
☐ Yes → If Yes (select all that apply):
☐ No ☐ First Nations
☐ Do not know ☐ I do not consent to provide this information ☐ Metis
☐ Inuk/Inuit

With which racial, ethnic or cultural group do you identify? (choose all that apply):

☐ Black
☐ Latin American
☐ Middle Eastern (Arab, Lebanese, Turkish, etc.)
☐ South East Asian (Filipino, Thai, Vietnamese, etc.)
☐ White (Caucasian)
☐ South Asian (Indian, Pakistani, Bangladeshi, etc.)
☐ East Asian (Chinese, Korean, Japanese, Taiwanese)
☐ Another racial, ethnic or cultural group: _____
☐ Do not know
☐ I do not consent to provide this information

In your opinion, do you have a disability?
☐ Yes
☐ No
☐ Do not know
☐ I do not consent to provide this information

If yes, what type(s) of disability do you have (select all that apply)

☐ Seeing ☐ Dexterity ☐ Developmental ☐ Mental health related
☐ Hearing ☐ Memory ☐ Flexibility ☐ Do not know
☐ Mobility ☐ Learning ☐ Pain-related ☐ Speech
☐ I do not consent to provide this information
☐ Other long term condition: _____

If Yes, how long have you had your disability? (If more than one disability, indicate the length of the longest disability):

_____Years _____Months ☐ Do not know ☐ I do not consent to provide this information

If yes, how often does your disability limit daily activity?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐ Do not know
☐ I do not consent to provide this information

Last modified: Nov 1st, 2023

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3. MY REQUEST *A proxy may sign for you if you are physically unable to sign the request, but CANNOT be the same person as Witness on page 3	
I am eligible for health services funded by a government in Canada, or am in the process of completing a waiting period to become eligible ☐Yes ☐No If Yes: ☐PEI Health Card ☐Other:_____	
By initialing and signing below, I confirm that	
Initials	I am making a request for MAiD of my own free will, without any influence or pressure from others.
Initials	I have been informed by a practitioner that I have an incurable illness, disease or disability.
Initials	I believe that my medical condition is serious and cannot be relieved by any means I accept.
Initials	Where required by law, I understand that my information will be shared with other health professionals directly involved in my care.
Initials	I can and have the right to change my mind and to ask questions at any time.

4. REQUESTOR SIGNATURE (must be signed in the physical or virtual presence of the Independent Witness on page 3)		
Signature of Requestor (hand-written signature required)	Print Name	Date Signed

PROXY SIGNATURE (IF APPLICABLE) (must be signed in the PHYSICAL presence of the Requestor and the physical or virtual presence of the Independent Witness listed on page 3, and on the same date)

By signing below as the Proxy on behalf of the Requestor, I confirm that:

- I am at least 18 years of age
- I understand the nature of the request for medical assistance in dying
- 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.
- I signed this request for MAiD in the physical presence of the person making the request, on their behalf under their express direction.

Signature of Proxy (hand written signature required)	Print Name	Relationship to Requestor
	Date Signed	Phone Number

Address	City	Province	Postal Code

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5. CONFIRMATION OF INDEPENDENT WITNESS (to be completed by the witness)	
By initialing and signing below, I confirm that:	
Witness	
Initials	a. I am at least 18 years of age and understand the nature of the request for medical assistance in dying
Initials	b. The Requestor is personally known to me or has provided proof of identity
Initials	c. The Requestor (or the Proxy in the presence and at the express direction of the Requestor) signed this request in my presence.
Initials	d. I do not know or believe that I am a beneficiary under the will of the Requestor, or a recipient, in other way of a financial or material benefit resulting from the Requestor's death.
Initials	e. I am not an owner or operator of a health care facility where the Requestor is receiving treatment or in which the Requestor resides.
Please initial the appropriate box "f" or "g" below that applies to you – only one box can be selected.	
Initials	f. I provide paid health care services or personal care services to the Requestor as part of my primary occupation and I am not the assessor, prescriber or consultant involved in the Requestor's assessment for MAiD. *
OR	
Initials	g. I do not provide health care services or personal care services directly to the Requestor.*
* A witness is still considered independent if they provide health care services or personal care to the Requestor as their primary occupation and are paid to do so, and are not the assessor, prescriber, or consultant involved in the Requestor's assessment for MAiD.	

6. SIGNATURE OF INDEPENDENT WITNESS (must be signed in the physical or virtual presence of the Requestor or Proxy, and on the same date.				
Signature of Witness (hand-written signature required)	Print Name		Relationship to Requestor	
	Date signed (YYYY/MM/DD)		Phone Number	
Address	City		Province	Postal Code

If you are approved for MAiD, and you are eligible to donate, would you like to be contacted about the option of organ and/or tissue donation? ☐ Yes ☐ No

Please ensure all of the boxes above are completed. To proceed with an assessment of eligibility, submit this form to your physician or nurse practitioner, or contact the Provincial Medical Assistance in Dying Program (contact information below). Please keep a copy of your request for your records.

Provincial MAiD Clinic
22 St. Peters Road
Charlottetown, PE
C1A 5N4
Phone: 902-288-1096
Fax: 902-288-1049
Email: pmc@ihis.org