Government of
Northwest Territories

FORM 2 – *Medical Assistance in Dying*

ASSESSMENT OF PATIENT BY ASSESSING PRACTITIONER

This form is to be completed by the Assessing Practitioner following receipt of a patient's Form 1 – *Formal Written Request* to record the Assessing Practitioner's assessment of the patient's eligibility for medical assistance in dying (MAID).

All information is mandatory unless indicated otherwise.

PRACTITIONER ACTIONS REQUIRED

- The following completed forms must be placed on the patient's medical record and copies securely emailed* or faxed to the MAID Review Committee **within 72 hours of the Assessing Practitioner's assessment**, regardless of whether the Assessing Practitioner determines the patient is eligible:
  - Form 1 – *Formal Written Request*
  - Form 2 – *Assessment of Patient by Assessing Practitioner*

  ** Completed forms being sent by email are to be sent via Secure File Transfer (https://sft.gov.nt.ca).*

MAID Review Committee
Phone: 867-767-9062 ext. 49190
Secure Fax: 867-873-2315
Email: MAID_ReviewCommittee@gov.nt.ca

- If the patient was deemed eligible, the Assessing Practitioner must ensure that a Consulting Practitioner assesses the patient to confirm that the patient meets the eligibility criteria. The Assessing Practitioner must ensure that a Consulting Practitioner has completed the following forms and has placed them in the patient's medical record:
  - Form 3 – *Assessment of Patient by Consulting Practitioner*

For assistance with facilitating access to another Practitioner, please contact the Central Coordinating Service:
Monday to Friday: 9:00am – 5:00pm
Toll Free: 1-833-492-0131
Email: maid_careteam@gov.nt.ca

1. PATIENT INFORMATION

Name:	
Date of Birth (dd/mm/yyyy):	Health Care Number:

2. ASSESSING PRACTITIONER INFORMATION

Name:	
NWT License Number:	Phone Number:
Are you a (choose one): ☐ Physician ☐ Nurse Practitioner	If you are a physician, what is your primary area of specialty? ☐ Family Medicine ☐ Other – specify: _____
Provide the mailing address at your primary place of work (street, city/town, postal code):	
Provide the email address that you use for work:	
To the best of your knowledge or belief, before you received the written request for MAID, did the patient consult you concerning their health for a reason other than seeking MAID? ☐ Yes ☐ No	

If you would like this information in another official language, contact us at 1-855-846-9601. / Si vous voulez ces informations dans une autre langue officielle, téléphonez-nous au 1-855-846-9601.

3. RECEIPT OF THE WRITTEN REQUEST

Date patient signed Form 1 – *Formal Written Request* (dd/mm/yyyy):

From whom did you receive the written request for MAID that triggered the obligation to provide information?

- ☐ Patient directly
- ☐ Another practitioner
- ☐ Care coordination service
- ☐ Another third party – specify: _____

Did the person previously make a separate request for MAID?

☐ Yes ☐ No ☐ Do not know

If yes, what was the outcome of that request?

- ☐ Assessed and found ineligible
- ☐ Assessed and found eligible, but patient withdrew request
- ☐ Assessed and found eligible, but considerable time elapsed since the assessment
- ☐ Request was not actioned
- ☐ Other – specify: _____

I have confirmed that the patient's request was:

- ☐ Signed and dated by the patient, or if applicable, by another person;
- ☐ Signed and dated **after** the patient was informed by a Practitioner that the patient has a Grievous and Irremediable Medical Condition; and
- ☐ Signed and dated before an independent witness who then also signed and dated the form.

4. ELIGIBILITY CRITERIA AND RELATED INFORMATION

A. Assessment Details

Date assessment by Assessing Practitioner began (dd/mm/yyyy):	Date assessment by Assessing Practitioner concluded (dd/mm/yyyy):

B. Eligibility Criteria*

*The following section lists the eligibility criteria as per the **Criminal Code**, and asks you to indicate whether you assessed it and, if so, your opinion as to the patient's eligibility, with relevant details where specified.*

A practitioner will not necessarily assess all criteria for every request. If a patient is ineligible based on one criterion, the practitioner may not have assessed the remaining criteria.

**** The patient must meet all criteria under this section to be eligible for MAID.***

Is the patient eligible for health services funded by a government of Canada? ☐ Yes ☐ No

Answer "Yes" if the patient would have been eligible but for an applicable minimum period of residence or waiting period.

Is the patient at least 18 years of age? ☐ Yes ☐ No

Is the patient capable of making decisions with respect to their health? ☐ Yes ☐ No

Did the patient make a voluntary request for MAID that, in particular, was not made as a result of external pressure? ☐ Yes ☐ No

If yes, specify why you are of the opinion that the request was voluntary and not as a result of external pressure (select all that apply):

- ☐ Consultation with patient
- ☐ Knowledge of patient from prior consultations or treatments for reasons other than MAID
- ☐ Consultations with other health or social services professionals
- ☐ Consultation with family members or friends
- ☐ Patient's medical records
- ☐ Other – specify: _____

If no, specify why you are of the opinion that the request was <u>not</u> voluntary and made as a result of external pressure:

Did the patient give informed consent to receive MAID after having been informed of the means that were available to relieve their suffering, including palliative care? ☐ Yes ☐ No

Does the patient have a serious and incurable illness, disease or disability? ☐ Yes ☐ No

If yes, indicate the illness, disease or disability (select all that apply):

- ☐ Cancer – specify primary site: _____
- ☐ Neurological condition – specify: _____
- ☐ Respiratory disease – specify: _____
- ☐ Cardio-vascular condition – specify: _____
- ☐ Other organ failure – specify: _____
- ☐ Diabetes
- ☐ Frailty
- ☐ Autoimmune condition
- ☐ Chronic pain
- ☐ Mental disorder (excludes neurocognitive/neurodevelopmental conditions) – specify: _____
- ☐ Other condition/co-morbidity – specify: _____

How long has the patient had a serious and incurable illness, disease or disability?

- ☐ Less than 3 months
- ☐ Between 3 months and less than 1 year
- ☐ Between 1 – less than 5 years
- ☐ Between 5 – less than 10 years
- ☐ Between 10 – less than 20 years
- ☐ 20 years or more
- ☐ Do not know

Is the patient in an advanced state of irreversible decline in capability? ☐ Yes ☐ No

If yes, what reasons led you to this opinion (select all that apply)?:

- ☐ Unable to do most or all activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) or marked decrease in ability to do these activities
- ☐ Reduced or minimal oral intake or difficulty swallowing
- ☐ Dependent on life sustaining treatments (e.g. transfusions, dialysis, feeding tube, O_2, bipap)
- ☐ Significant dependence on aid(s) for interaction (e.g., hearing aids, magnifying equipment, speech supports, memory strategies) and/or mobility, or advanced beyond use of these aids or marked decrease in ability to do these activities
- ☐ Significant shortness of breath or marked increase
- ☐ Persistent significant fatigue/weakness or marked increase
- ☐ Cachexia (extreme weight loss and muscle wasting due to severe chronic illness) or marked change in weight and/or muscle mass
- ☐ Other – specify: _____

Does the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they considered acceptable? ☐ Yes ☐ No

If yes, indicate how the patient describes their suffering (select all that apply):

- ☐ Loss of ability to engage in activities making life meaningful (e.g., physical/social/leisure activities important to the individual)
- ☐ Loss of dignity
- ☐ Isolation or loneliness
- ☐ Loss of ability to perform activities of daily living (e.g. bathing, food preparation, finances)
- ☐ Loss of control of bodily functions
- ☐ Perceived burden on family, friends or caregivers
- ☐ Inadequate pain control, or concern about it
- ☐ Inadequate control of other symptoms, or concern about it
- ☐ Emotional distress/anxiety/fear/existential suffering
- ☐ Loss of independence (e.g., having full or majority of autonomy over one's life)
- ☐ Other – specify: _____

C. Services Received

Receipt of these services does not affect the patient's eligibility for MAID.

i. Palliative Care

Did the patient require palliative care? ☐ Yes ☐ No ☐ Do not know

If yes, answer subsequent questions

Where the patient <u>required</u> palliative care:

Did the patient **receive** palliative care (not required to be a formal palliative care program)? ☐ Yes ☐ No ☐ Do not know

If the patient **did not** receive palliative care, to the best of your knowledge or belief, was palliative care accessible to the patient?

☐ Yes ☐ No ☐ Do not know

Where the patient <u>received</u> palliative care:

For how long did the patient receive palliative care?

☐ Less than 2 weeks ☐ 2 weeks to less than 1 month ☐ 1 to 6 months
☐ More than 6 months ☐ Do not know

Where did the patient receive palliative care (select all that apply)?

☐ Home-based ☐ Hospital-based (in-patient) ☐ Hospice care
☐ Hospital-based outpatient or medical clinic/ambulatory service ☐ Long-term care facility ☐ Do not know

What were the types of palliative care received (check all that apply)?:

☐ Pain/symptom management ☐ Personal support services (e.g., PSW care) ☐ Volunteer supports
☐ Psychosocial care and/or counselling ☐ Spiritual care and/or counselling ☐ Palliative chemotherapy
☐ Palliative radiation therapy ☐ Physiotherapy ☐ Occupational therapy
☐ Do not know ☐ Other – specify: _____

ii. Disability Support Services

Did the patient require disability support services? ☐ Yes ☐ No ☐ Do not know

If yes, answer subsequent questions

Where the patient <u>required</u> disability support services:

Did the patient **receive** disability support services? ☐ Yes ☐ No ☐ Do not know

If the patient **did not** receive disability support services, to the best of your knowledge or belief, were disability support services accessible to the person?

☐ Yes ☐ No ☐ Do not know

Where the patient <u>received</u> disability support services:

For how long did the patient receive disability support services?

☐ Less than 6 months ☐ 6 months to less than 1 year ☐ 1 year to less than 2 years
☐ 2 years or more ☐ Do not know

What were the disability support services received (select all that apply)?:

☐ Aids to support physical mobility (i.e. walker, wheelchair, cane, scooter)
☐ Aids to support audio/visual/communication (i.e., hearing aid, large print materials, magnifiers, communication boards, eye gaze technology, write boards)
☐ Aid to support safety/access/transfers/ADLs (i.e., handrails, bath seat, ramps, commode, bed rail, transfer board, lift, adapted utensils)
☐ Income supports (i.e., WSIB, CPP-D, ODSP, STD, LTD, insurance settlements)
☐ Mental health / social support professional services (i.e., Social work, psychotherapy, counselling, case worker)
☐ Physical support services (i.e., PSW, supervision for personal care, OT/PT, nursing)
☐ Physiotherapy
☐ Other – specify: _____
☐ Do not know

D. Procedural Requirements

I have:

☐ Provided the patient with information on the feasible alternatives to MAID (ex. palliative care, pain management, etc.);
☐ Provided the patient with information on the risks of taking the medication(s) for MAID;
☐ Provided the patient with information on the probable outcome of taking medication for MAID;
☐ Recommended to the patient that they seek legal advice with respect to estate planning and life insurance implications;
☐ Offered to discuss the patient's MAID choice with the patient and the patient's family;
☐ Assessed the patient to determine if their natural death is reasonably foreseeable, taking into account all of the patient's medical circumstances;
☐ Ensured the patient is capable of providing informed consent to receive MAID, consulting with other health care professionals as required; and
☐ Informed the patient of their ability to withdraw their request for MAID at any time and in any manner.

I state and confirm that I:

☐ Am not a mentor to the other Practitioners involved in the MAID process or responsible for supervising their work;
☐ 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 death of the patient; and
☐ Do not know or believe that I am connected to the other Practitioners involved in the the MAID process, or to the patient making the request, in any way that affects my objectivity.

E. Finding of Eligibility or Ineligibility

I have determined that the patient currently:

☐ Meets the eligibility criteria for MAID

OR

☐ Does not meet the eligibility criteria for MAID

If eligible:
I have determined that the patient's natural death is:

☐ Reasonably foreseeable (Track 1) ☐ Not reasonably foreseeable (Track 2)*

NOTE: *If Track 2, you must provide additional information regarding procedural requirements.* ***See Part F*.**

If ineligible:
Had you or another Practitioner previously determined that the patient was eligible for MAID?

☐ Yes ☐ No ☐ Do not know

If yes, please indicate why you have determined that the patient is no longer eligible:

☐ The patient lost the capacity to make decisions with respect to their health;

☐ You became aware that the patient's request was not voluntary;

☐ Other eligibility criterion, procedural requirement, or safeguard was not met (please specify which one(s) and the reason you made this determination):

Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory assessment by Consulting Practitioner or practitioner providing assessment expertise for patients whose natural death is not reasonably foreseeable)?

☐ Yes ☐ No

If yes, indicate what type of professional you consulted (select all that apply):

☐ Nurse ☐ Oncologist ☐ Palliative care specialist ☐ Primary care provider
☐ Psychiatrist ☐ Social worker ☐ Other – specify: _____

F. Additional Safeguards – Natural Death not Reasonably Foreseeable (Track 2)*

**** Only complete this section if patient's death is not reasonably foreseeable.***

i. Information on Means to Relieve Suffering

☐ I have ensured that the patient has been informed of the reasonable and alternative means to relieve the patient's suffering, including, where appropriate under the circumstances, counselling services, mental health and disability support services, community care, and palliative care; and

☐ I have ensured that the patient has been offered consultations with relevant professionals who provide such services.

Which means to relieve their suffering were discussed and offered to the patient (select all that apply)?:

☐ Pharmacological
☐ Non-pharmacological (e.g. neuro stimulation, ECT)
☐ Counselling
☐ Mental health support
☐ Disability support
☐ Community services – income
☐ Community Services – housing
☐ Community services – other – specify: _____
☐ Health Care services including Palliative care
☐ Other – specify: _____

☐ I have discussed with the patient the reasonable and alternative means to relieve the patient's suffering; and

☐ I agree with the patient that the patient has given serious consideration to those means.

How and on what basis did you form the opinion that the patient has given serious consideration to the means to relieve their suffering (select all that apply)?:

☐ Consultation with patient
☐ Consultation with family/friends
☐ Consultation with professional care/medical providers
☐ Accepted/attempted multiple treatments appropriate for the condition
☐ Previous knowledge of patient
☐ Receptive to discussion on available means to relieve suffering
☐ Review of medical records
☐ Other – specify: _____

ii. Assessment Expertise

The Practitioner with the requisite expertise in the condition causing the patient's suffering* is/will be:

☐ Myself (the Assessing Practitioner)
☐ The Consulting Practitioner
☐ Another Practitioner, who has/will share the results of their consultation with:
  ☐ Myself (the Assessing Practitioner)
  ☐ The Consulting Practitioner

The Practitioner's expertise as it relates to the condition causing the patient's suffering is (select all that apply):

☐ Cardiology
☐ General Internal Medicine
☐ Geriatric Medicine
☐ Nephrology
☐ Neurology
☐ Oncology
☐ Psychiatry
☐ Pain Management
☐ Respiratory Medicine
☐ Other – specify: _____

** Having expertise does not require that the Practitioner be licensed as a specialist for that condition.*

iii. Assessment Period

☐ I have informed the patient that a 90 day mandatory Assessment Period must pass before MAID can be provided.

☐ I have assessed the patient to determine if the patient is at imminent risk of losing capacity to provide consent to receive MAID, and:

A. Assessment Period Amendment Required

☐ I have determined in consultation with the patient, that the patient is at imminent risk of losing such capacity*;

☐ I have informed the patient of this risk and of the various options available, including the ability to shorten the Assessment Period; and

☐ I have determined that a shorter assessment period of _____ days is appropriate in the circumstances;

OR

B. No Assessment Period Amendment Required

☐ I have determined that the patient is not at risk of losing such capacity at this time.

** The patient is not eligible for a shorter Assessment Period until the Consulting Practitioner has confirmed that it is appropriate in the circumstances.*

Assessment Notes

5. SIGNATURE OF ASSESSING PRACTITIONER

X _____ _____ _____

Signature of Assessing Practitioner | Date (dd/mm/yyyy) | Time

You may print this form to sign

The personal health information on this form is being collected under the authority of the *Criminal Code of Canada*. It is protected by the privacy provisions under the federal *Privacy Act* and the Northwest Territories *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the *Privacy Act*, HIA, or any other Act. If you have any questions about this form, please contact the Medical Assistance in Dying Review Committee at 867-767-9062 ext. 49190.