Government of
Northwest Territories

FORM 3 – *Medical Assistance in Dying*

ASSESSMENT OF PATIENT BY CONSULTING PRACTITIONER

This form is to be completed by a Consulting Practitioner to record the Consulting Practitioner's assessment of the patient's eligibility for medical assistance in dying (MAID), following, or at the same time as, the Assessing Practitioner's finding of a patient's eligibility for MAID, (i.e., the "Date assessment by Consulting Practitioner concluded" in Part 3 must be the same or later than the "Date assessment by Assessing Practitioner concluded" in Part 4 of Form 2 – *Assessment of Patient by Assessing Practitioner*).

All information is mandatory unless indicated otherwise.

CONSULTING PRACTITIONER ACTIONS REQUIRED

- The completed form must be placed on the patient's medical record and a copy securely emailed* or faxed to the MAID Review Committee **within 72 hours of the Consulting Practitioner's assessment**, regardless of whether the Consulting Practitioner determines the patient is eligible.

  ** 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

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. CONSULTING 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. ELIGIBILITY CRITERIA AND RELATED INFORMATION

A. Assessment Details

Date assessment by Consulting Practitioner began (dd/mm/yyyy):	Date assessment by Consulting 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 in 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 increase in 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
- ☐ Persistent, significant, and escalating chronic pain
- ☐ 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. Procedural Requirements

I have:

- ☐ Ensured the patient is capable of providing informed consent to receive MAID, consulting with other health care professionals as required;
- ☐ Assessed the patient to determine if their natural death is reasonably foreseeable, taking into account all of the patient's medical circumstances; 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 MAID process, or to the patient making the request, in any way that affects my objectivity.

D. 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 E*.**

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 Assessing Practitioner)?

☐ Yes ☐ No

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

☐ Nurse ☐ Oncologist ☐ Palliative Care Specialist ☐ Primary Care Provider
☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Speech Pathologist
☐ Other health care professional – specify: _____

E. 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 Consulting Practitioner)

☐ The Assessing Practitioner

☐ Another Practitioner, who has shared the results of their consultation with:

- ☐ Myself (the Consulting Practitioner)
- ☐ The Assessing 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 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 and in agreement with the Assessing Practitioner, that the patient is at imminent risk of losing such capacity and that a shorter Assessment Period 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.

Assessment Notes

4. SIGNATURE OF CONSULTING PRACTITIONER

X _____ _____ _____

Signature of Consulting Practitioner
You may print this form to sign

Date (dd/mm/yyyy)

Time

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.