Government of
Northwest Territories

FORM 4 – *Medical Assistance in Dying*

WITHDRAWAL OF REQUEST

This form must be completed by a Practitioner who received a patient's request for medical assistance in dying (MAID), whether verbal or written, within 72 hours of becoming aware of the withdrawal of the patient's request for MAID.

All information is mandatory unless indicated otherwise.

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 Practitioner becoming aware of the withdrawal of the patient's request for MAID**.

  ** 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

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

A. Required Information

Name:

Sex at Birth: ☐ Male ☐ Female ☐ Other – specify: _____

Postal Code:

Date of Birth (dd/mm/yyyy):

Health Care Number:

☐ Not Applicable

Province or Territory that Issued the Health Care Number:

If the patient does not have a health insurance number, please indicate the province or territory of their usual place of residence.

B. Optional Information – if known

Proceed to Section 2 if optional information has already been provided in Form 1 – Formal Written Request.

Gender Identity:

☐ Male ☐ Female ☐ Other – specify: _____ ☐ Do not know

Indigenous Identity (choose all that apply):

☐ First Nations ☐ Inuk/Inuit ☐ Métis ☐ Non-Indigenous ☐ Do not know

Racial, Ethnic, or Cultural Group (choose all that apply):

☐ Black
☐ Latin American
☐ South-east Asian (Filipino, Thai Vietnamese, etc.)
☐ Caucasian (white)
☐ Do not know
☐ East Asian (Chinese, Korean, Japanese, Taiwanese, etc.)
☐ Middle Eastern (Arab, Persian Lebanese, Turkish, etc.)
☐ South Asian (Indian, Pakistani, Bangladeshi, etc.)
☐ Another racial, ethnic, or cultural group – specify: _____

Disabilities:
In the patient's opinion, did they have a disability?

☐ Yes ☐ No ☐ Do not know

If yes:

A. Which of the following best describes the type of disability (choose all that apply):

☐ Seeing ☐ Hearing ☐ Mobility ☐ Flexibility ☐ Dexterity
☐ Pain-related ☐ Learning ☐ Developmental ☐ Mental health related ☐ Memory
☐ Other long term condition – specify: _____ ☐ Do not know

B. In the patient's opinion, how often did their disability limit their daily activities?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐ Do not know

C. How long had the patient had the disability?

☐ _____ Years ☐ _____ Months ☐ Do not know

2. PRACTITIONER INFORMATION

Name:

NWT License Number:	Phone Number:

Are you a (choose one):	If you are a physician, what is your area of specialty?
☐ Physician ☐ Nurse Practitioner	☐ 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

3. RECEIPT OF THE REQUEST

Date of receipt of request (dd/mm/yyyy):

Request was made:

☐ Verbally ☐ In writing: Form 1 – Formal Written Request ☐ In writing, other – specify: _____

From whom did you receive the request for MAID?

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

If known, did the patient previously make a written 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: _____

4. WITHDRAWAL

The patient withdrew their request for MAID:

- ☐ When given the opportunity to withdraw immediately before providing MAID; or
- ☐ At another time.

If known, what were the patient's reasons for withdrawing their request for MAID (select all that apply)?:

- ☐ Means to relieve their suffering were accepted by the person
- ☐ Individuals who the person considers important in their lives (e.g., religious leaders, family caregivers, or processionals) do not support MAID
- ☐ Upon learning additional information about MAID, the patient decided it was not the path they wish to pursue
- ☐ Meeting the needs of a transfer and/or consultation were too cumbersome for the patient
- ☐ Other – specify:

If means to relieve their suffering were accepted and led the person to withdraw their request, which of these means were pursued (select all that apply)?:

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

5. SIGNATURE OF PRACTITIONER

X _____ _____ _____

Signature of 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.