Government of
Northwest Territories

FORM 9 – *Medical Assistance in Dying*

DEATH OF PATIENT FROM OTHER CAUSE

This form is to be completed by a Practitioner who receives **ANY FORM** of a request for medical assistance in dying (MAID) and becomes aware of the patient's death from a cause other than MAID:

- Within 90 days of receiving the request if the patient's death was reasonably foreseeable, or
- Within two years of receiving the request if the patient's death was not reasonably foreseeable.

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 30 days of the Practitioner becoming aware of the patient's death.**

  ** 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

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.

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)
☐ 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: _____
☐ Do not know

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):

☐ Physician ☐ Nurse Practitioner

If you are a physician, what is your 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

3. RECEIPT OF THE REQUEST

From whom did you receive the 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: _____

4. DEATH OF PATIENT FROM OTHER CAUSE

Date of patient's death (if known): _____
(dd/mm/yyyy)

Did you complete the patient's medical certificate of death?

☐ Yes ☐ No

If yes, what was the patient's (as indicated on the certificate):

- Immediate cause of death:

- Underlying cause(s) of death:

If known, what was the underlying reason(s) that led to the person dying of a natural death, before receiving MAID (select all that apply)?:

☐ Patient was referred or requested MAID too late (i.e. referral time was too short)
☐ Patient died before both assessments were completed
☐ Person was found eligible but died before scheduled MAID provision
☐ Patient never chose a date to proceed with MAID provision
☐ No assessor/provider available/willing
☐ Operational issues (i.e., could not be moved to a facility that allowed MAID, medication shortages, bed shortages, health care personnel unavailable)
☐ Loss of capacity to consent without Advance Consent being completed
☐ Lack of pharmacy willing to provide MAID medications
☐ Other – specify: _____
☐ Do not know

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.