



MEDICAL ASSISTANCE IN DYING (MAiD) - PROVISION DOCUMENTATION

Patient Name:	HCN:	DOB (YYYY/MON/DD):
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Provision Location:	☐ Private Residence	☐ Nursing Home/LTC Facility
	☐ Hospital/NS Health Facility	☐ Other

Health Care Providers Present:	
Name	Designation
Family/Friends Present:	

Pre-Provision Requirements:	
The First and Second assessments have been completed and agree that the patient meets MAiD eligibility criteria.	☐ Yes
The appropriate <i>MAiD Patient Request and Consent Form</i> has been signed and dated, including the signature of one independent witness: Dated (YYYY/MON/DD):	☐ Yes
Immediately prior to providing MAiD, the patient was given the opportunity to withdraw their request for and consent to MAiD, or <i>Waiver of Final Consent</i> was signed and dated: Dated (YYYY/MON/DD):	☐ Yes
If Non-Reasonably Foreseeable Natural Death (Non-RFND) , do you or the other assessor have expertise in the condition causing the person's suffering?	☐ Yes ☐ No ☐ N/A
If Non-RFND , was a specialty consultation required for this case? If Yes, indicate the specialty consulted:	☐ Yes ☐ No ☐ N/A
If Non-RFND , was the 90-day waiting period completed?	☐ Yes ☐ No ☐ N/A
If Non-RFND , was the waiting period shortened because the patient was at risk of losing capacity?	☐ Yes ☐ No ☐ N/A

Provision Details - Intravenous Access:
IV Inserted in advance (or PICC Line/Port-a-Cath Accessed): ☐ Yes By: _____
IV Inserted by Provider: ☐ Yes Site 1: _____ Size _____ G / Site 2: _____ Size _____ G OR PICC Line/Port-a-Cath Accessed by Provider: ☐ Yes
☐ Saline lock only OR ☐ Solution _____ at _____ mL/h Time started (HH:MM): _____
IV site used for provision: _____



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Waiver of Final Consent:	
Was a <i>Waiver of Final Consent</i> form completed by this patient?	☐ Yes ☐ No
For those who completed a <i>Waiver of Final Consent</i> , was it implemented (i.e., the person lost capacity and was not able to provide final consent immediately before MAiD was provided)?	☐ Yes ☐ No ☐ N/A

Medications Administered:				
Time (HH:MM)	Medication	Dose	Route	Signature

Death Details:		
Date (YYYY/MON/DD):	Time of Death (HH:MM):	Death Pronounced by:
Death Certificate completed (in blue pen): ☐ Yes		
Plan for body retrieval discussed with family and care team: ☐ Yes		
Comments: 		
NB: It is the responsibility of the providing clinician to complete the Health Canada MAiD Portal.		

MAiD Provider Details:	
Attending Physician/Nurse Practitioner (print)	Attending Physician/Nurse Practitioner (sign)
License Number:	Date (YYYY/MON/DD): _____ Time (HH:MM): _____

