Ontario

Ministry of Health

Clinician Aid A
Patient Request for Medical Assistance In Dying

Medical Assistance in Dying means**:** (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Authorized third person is a person who is at least 18 years of age and who understands what it means to request medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death may sign and date the request in the presence and on behalf of the person requesting medical assistance in dying.

An independent witness is any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying who (a) does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death; (b) is not an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides. An independent witness may include a person who is paid to provide health care services or personal care to the person requesting medical assistance in dying. A medical assistance in dying provider, assessor or where applicable, the consulting practitioner with expertise in the condition causing the person's suffering is not permitted to act as a witness.

A person is considered to have a **grievous and irremediable** medical condition where:

- they have a serious and incurable illness, disease or disability; and,
- they are in an advanced state of irreversible decline in capability; and,
- they are experiencing enduring physical or psychological suffering, due to the illness, disease, disability or state of decline, that is intolerable to the person and cannot be relieved in a manner that they consider acceptable;

Note: Persons whose sole underlying medical condition is a mental illness, and who otherwise meet all eligibility criteria, are not currently eligible for MAID. The term mental illness does not include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities.

The use of this aid is voluntary. It is being provided to assist you in making a written request for medical assistance in dying that complies with the legal requirements.

Once you complete this request, you should provide it to your doctor or nurse practitioner. The completed aid may be included in your medical records and may be used by your doctor or nurse practitioner to provide health care to you.

Section 1 – Patient Information

Last Name	First Name		
Gender ☐ Male ☐ Female ☐ Other	Date of Birth (yyyy/mm/dd)	Health Insurance Number (e.g., OHIP Number) ☐ Not Applicable	Version Code
Province or Territory that Issued Health Insurance Number		Postal Code Associated with Patient's Home Address ☐ Patient does not have a home address	

Section 2 – Request for Medical Assistance in Dying

You must personally verify all data in this section and sign your own name. If you are unable to sign for yourself you may ask an authorized third person to complete it for you and sign their name in Section 3 under authorized third person signature.

I, _____
(Last Name, First Name)

request that a doctor or nurse practitioner help me to die. I confirm that:

☐ I am eligible for health services funded by a government in Canada (i.e., I have a valid OHIP card or proof of other Canadian publicly- funded health insurance – e.g., from another province) or, but for any applicable minimum period of residence or waiting period, I would be eligible for health services funded by a government in Canada.

☐ I am at least 18 years of age.

☐ I have been informed by my doctor or nurse practitioner that I have a **grievous and irremediable** condition.

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Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

☐ I am asking for help to die voluntarily and not as a result of pressure from others.

☐ I am giving my informed consent to receive medical assistance in dying, and have been informed of the means that are available to me to relieve my suffering, including palliative care.

Signature (Patient)	Date (yyyy/mm/dd)

Section 3 – Authorized Third Person (where the person requesting medical assistance in dying is unable to sign and date the request)

Last Name	First Name

Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number ext.	Relationship to Person Requesting Medical Assistance in Dying

By signing below on the person's behalf, I declare that:

☐ I am at least 18 years of age;

☐ I understand the nature of the person's request for medical assistance in dying;

☐ I do not know or believe that I am a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death; and

☐ I am signing under the person's presence, on the person's behalf and under the person's express direction.

Signature (Third Person)	Date (yyyy/mm/dd)

Section 4 – Witness Present Upon Signing and Declaration of Witness

This section must be completed by one independent witness. An independent witness may include a person who is paid to provide health care services or personal care to the person requesting medical assistance in dying. A medical assistance in dying provider, assessor, or where applicable, the consulting practitioner with expertise in the condition causing the person's suffering is not permitted to act as a witness.

Witness Information

Last Name	First Name

Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code	Telephone Number ext.

Relationship to Person Requesting Medical Assistance in Dying

☐ Family * (Specify) _____

☐ Volunteer

☐ Friend

☐ Neighbour

☐ Hospital/care staff

☐ Other (Specify) _____

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)

* Neither myself nor my spouse are beneficiaries under the will of the person making the request, or a recipient, in any other way, of a financial or some other material benefit resulting from that person's death.

By signing below, I declare that:

☐ I do not know or believe that I am (a) a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or some other material benefit resulting from that person's death; (b) are the owner or operator of any health care facility at which the person making the request is being treated or in any facility in which that person resides.

Signature (Witness)	Date (yyyy/mm/dd)