RÉSEAU DE SANTÉ **Horizon** HEALTH NETWORK

Medical Assistance in Dying (MAID)
Patient Request Form

Patient Label

1. PATIENT INFORMATION		
Patient Last Name	Patient First Name	Patient Middle Name (if applicable)
Date of Birth (month/dd/yyyy)	Medicare Number	Health Record Number
Primary Care Practitioner	Phone Number	Diagnosis

By checking the boxes and signing below, I the patient, confirm that:

- ❑ I am making a voluntary request for MAID of my own free will without external pressure to do so.
- ❑ I am aware that I will be assessed by two independent healthcare providers (physician or nurse practitioner) to determine if I meet the eligibility criteria to receive MAID.
- ❑ I understand that MAID involves a physician/nurse practitioner prescribing medication that I may self-administer, or the physician/nurse practitioner prescribing and administering medication that will result in my death.
- ❑ I give permission for my medical records to be reviewed by the physician/nurse practitioners and care team reviewing my eligibility for MAID.
- ❑ I understand that MAID documents will be retained for the purpose of monitoring medical assistance in dying processes.
- ❑ I understand that I have the right to withdraw my request for MAID at any time.

Patient Signature	Patient Name	Date (month/dd/yyyy)

PROXY SIGNATURE (NOTE: this area is only completed if patient is unable to physically sign on their own)

- ❑ I am at least 18 years of age and understand the nature of a MAID request
- ❑ I am not a beneficiary under the WILL of the patient named above, or a recipient in any other way of financial or material benefits resulting from the patient's death
- ❑ I am signing this document on behalf of the patient named above in their presence under their expressed direction

Proxy Signature	Name (Print)	Date (month/dd/yyyy)

2. WITNESS SIGNATURE / CONFIRMATION OF INDEPENDENT WITNESS

By checking the boxes and signing below, I confirm that:

- ❑ I am at least 18 years of age, and I understand that I have been requested to provide written confirmation that I witness the signature of the patient making the request for MAID.
- ❑ I am not a beneficiary under the WILL of the patient named above, or a recipient in any other way of financial or material benefits resulting from the patient's death.
- ❑ I am not an owner or operator of a health care facility where the patient named above resides or is receiving treatment.
- ❑ The patient named above (or their proxy, in the presence and at the expressed direction of the patient) signed this request for MAID in my presence.
- ❑ I declare that the patient has expressed to me that they are making a voluntary request for MAID without external pressure to do so.
- ❑ I am not a physician/nurse practitioner that has or will provide assessment of eligibility for MAID.

Independent Witness Signature	**Name (Print)**	**Date (month/dd/yyyy)**