MEDICAL ASSISTANCE IN DYING (MAID) – PROVISION DOCUMENTATION

Patient Name:	**HCN:**	**DOB** (YYYY/MON/DD):

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 *MAID Patient Request and Consent Form* 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 *Advance Request – Waiver of Final Consent* was signed and dated: Dated (YYYY/MON/DD):	❑ **Yes**
If 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 shortened because the patient was at isk of losing capacity?	❑ **Yes** ❑ **No** ❑ **N/A**

Provisions 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: ________
IV site used for provision: ____________________

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Advance Request – Waiver of Final Consent:	
Was an *Advanced Request – Waiver of Final Consent* form **completed** by this patient?	❑ **Yes** ❑ **No**
For those who completed an *Advance Request – Waiver of Final Consent* **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	Medication	Dose	Route	Signature

Death Details:

Date (YYYY/MON/DD):	Time of Death:	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: _________

NSMAIDPD