nova scotia health authority

Label

Medical Assistance in Dying (MAID)
First Physician / Nurse Practitioner Assessment

Patient Information:

First Name: ___________________________ Surname: ______________________________

Date of Birth: yyyy / mm / dd Age: _______ NS HCN: _______________________________

Family Physician: ____

Diagnosis: ____

First Physician / Nurse Practitioner Assessment:

Date: yyyy / mm / dd

Location: ☐Hospital _____________ ☐Patient's Home ☐Other______________________

With respect to the patient named above:

- He/she is eligible for health services funded by the Province of Nova Scotia and holds a health card issued by the Province. ☐Yes ☐No
- He/she is at least 18 years of age. ☐Yes ☐No
- He/she has been provided with a copy of the *'Professional Standard regarding Medical Assistance in Dying'* of the College of Physicians and Surgeons of Nova Scotia or the College of Registered Nurses of Nova Scotia's document entitled *Medical Assistance in Dying: A Practice Guideline for Nurse Practitioners.* .
  ☐ Yes ☐No
- He/she is capable of making decisions with respect to medical assistance in dying.
  ☐Yes ☐No
- He/she is acting voluntarily in making this request. ☐Yes ☐No
- He/she has a grievous and irremediable medical condition and his/her natural death has become reasonably foreseeable, taking into account all of their medical circumstances.
  ☐Yes ☐No
- He/she has verbally reiterated his or her request for medical assistance in dying after having been fully informed of his or her right to rescind the request ay any time.
  ☐Yes ☐No
- The patient and I have discussed the patient's diagnosis, prognosis, and treatment options, including the availability of palliative care. ☐Yes ☐No
- The *'Request for and Consent to Medical Assistance in Dying'* Form has been signed and dated by the patient, including the signatures of two independent witnesses.
  ☐Yes Date yyyy / mm / dd ☐No*

Comments:____

First Physician / Nurse Practitioner (print)	Signature of First Physician / Nurse Practitioner	Date
______________________________	______________________________	yyyy / mm / dd

License Number: _________________

* If the Request and Consent form has *not* been completed, it ***must*** be completed and presented to the Second Physician / Nurse Practitioner at the time of their assessment.

nova scotia health authority

Label

Medical Assistance in Dying (MAID)
Second Physician / Nurse Practitioner Assessment

Patient Information:

First Name: ____________________________ Surname: _______________________________

Date of Birth: yyyy / mm / dd Age: _______ NS HCN: ________________________________

Family Physician: ____

Diagnosis: ____

Second Physician / Nurse Practitioner Assessment:

Date: yyyy / mm / dd

Location: ☐Hospital _____________ ☐Patient's Home ☐Other_______________________

With respect to the patient named above:

- I have reviewed the documentation provided by the First Physician / Nurse Practitioner
  ☐Yes ☐No
- He/she is eligible for health services funded by the Province of Nova Scotia and holds a health card issued by the Province. ☐Yes ☐No
- He/she is at least 18 years of age. ☐Yes ☐No
- He/she has been provided with a copy of the *'Professional Standard regarding Medical Assistance in Dying'* of the College of Physicians and Surgeons of Nova Scotia the College of Registered Nurses of Nova Scotia's document entitled *Medical Assistance in Dying: A Practice Guideline for Nurse Practitioners.* ☐Yes ☐No
- He/she is capable of making decisions with respect to medical assistance in dying.
  ☐Yes ☐No
- He/she is acting voluntarily in making this request. ☐Yes ☐No
- He/she has a grievous and irremediable medical condition and his/her natural death has become reasonably foreseeable, taking into account all of their medical circumstances.
  ☐Yes ☐No
- He/she has verbally reiterated his or her request for medical assistance in dying after having been fully informed of his or her right to rescind the request ay any time.
  ☐Yes ☐No
- The patient and I have discussed the patient's diagnosis, prognosis, and treatment options, including the availability of palliative care. ☐Yes ☐No
- The *'Request for and Consent to Medical Assistance in Dying'* Form has been signed and dated by the patient, including the signatures of two independent witnesses.
  ☐Yes Date yyyy / mm / dd ☐No

Comments:____

Second Physician / Nurse Practitioner (print)	Signature of Second Physician / Nurse Practitioner	Date
______________________________	_________________________________	yyyy / mm / dd

License Number: _________________

nova scotia health authority

Label

Medical Assistance in Dying (MAID)
Pre-Procedure Documentation

Patient Information:

First Name: ____________________________ Surname: _______________________________

Date of Birth: yyyy / mm / dd Age: _______ NS HCN: ________________________________

Family Physician: ____

Diagnosis: ____

Date of Procedure: yyyy / mm / dd

Location: ☐Hospital _____________ ☐Patient's Home ☐Other______________________

Health Care Providers Present (name, designation)

1. ______________________________, ______________________________
2. ______________________________, ______________________________
3. ______________________________, ______________________________
4. ______________________________, ______________________________

Family / Friends present: ____

Pre-Procedure Requirements:

- The First and Second Physicians/Nurse Practitioners' assessments have been completed, and are in agreement. ☐Yes ☐No
- The *'Request for and Consent to Medical Assistance in Dying'* Form has been signed and dated by the patient, including the signatures of two independent witnesses.
  ☐Yes Date yyyy / mm / dd ☐No
- The required 10 day period between the day on which the request was signed and the day on which medical assistance in dying is to be provided has been met.
  ☐Yes ☐No*

  *If no, the specific reason for the alternation in the time interval must be indicated, and agreed upon by both the First and Second Physician / Nurse Practitioner**:**
  ____
  ____

  First Physician / Nurse Practitioner (print) ________________________________

  Signature of First Physician / Nurse Practitioner ________________________________

  Second Physician / Nurse Practitioner (print) ________________________________

  Signature of Second Physician / Nurse Practitioner ________________________________

- Immediately prior to providing the medical assistance in dying, the patient was given the opportunity to withdraw their request for and consent to medical assistance in dying. ☐Yes ☐No
- The medications to be administered are available. ☐Yes ☐No

Attending Physician / Nurse Practitioner (print) ________________________________

Signature of Attending Physician / Nurse Practitioner ________________________________

License Number: __________________

Date: yyyy / mm / dd Time:

nova scotia health authority

Label

Medical Assistance in Dying (MAID)
Procedure Documentation

Patient Information:

First Name: ______________________________ Surname: _________________________________

Date of Birth: yyyy / mm / dd Age: ________ NS HCN: __________________________________

Family Physician: ____

Diagnosis: ____

Procedure:

□ **Intravenous**

Time started: ________ Solution ________________ Inserted with # ____ G Insyte

□ Rt □ Lt _____________ at _________ mL/hr started by: __________________________________

Medication(s) Administered:

Time	Medication	Dose	Route	Signature

Interdisciplinary Progress Notes

Date	**Time 24hr**	**Dept**	**Focus**	**D –** Data **A –** Action **R –** Response **P -** Plan

Post Procedure

Date: _________ Time: ______ of Death. Pronounced by:________________________________

Death Certificate Signed: □ Yes □ No Comment: _________________________________

Time body was removed: ______ Body taken to: _______________________________________

Procedural checklist has been completed □ **Yes** □ **No**

Comments: ____

____

____

Attending Physician/Nurse Practitioner (Print) Signature of Attending Physician/Nurse Practitioner Date

__________________ ___________________ _______