Ontario

Ministry of Health and Long-Term Care

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.

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 may act as an independent witness, except if they (a) 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) are 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; (c) are directly involved in providing health care services to the person making the request; or (d) directly provide personal care to the person making the request.

Authorized third person in accordance with ss. 241.2(4) of the Criminal Code, is a person who is at least 18 years of age and who understands the nature of the request for 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.

A **grievous and irremediable** medical condition is defined as:

- having a serious and incurable illness, disease or disability; and,
- being in an advanced state of irreversible decline in capability; and,
- 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; and,
- where the person's natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without requiring a specific prognosis as to the length of time the person has left to live.

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	Date of Birth (yyyy/mm/dd)	Ontario Health Insurance Plan (OHIP) Number	Version Code
☐ Male ☐ Female ☐ Other			

Proof of other publicly-funded health insurance (For non-OHIP patients only)	Postal Code

Section 2 - Request for Medical Assistance in Dying

You must personally complete this section unless you are unable to sign. If you are unable to sign, you may ask an **authorized third person** to complete this section for you.

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.

☐ 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

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

Section 4 - Witnesses present upon signing

(Information on who is eligible to sign as witness can be found under "Declaration of Witness" in Section 5 of the form (below). The two witnesses must fill out the information in Section 5 as well.)

Signature (Witness #1)	Date (yyyy/mm/dd)

Signature (Witness #2)	Date (yyyy/mm/dd)

Section 5 - Declaration of Witness

This section should be completed by two independent witnesses

Witness #1 Information

Last Name	First Name

Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number ext.

By signing the below, I declare that:

☐ I am at least 18 years of age;

☐ I understand the nature of the request above 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;

☐ I am not an owner or operator of any health facility at which the person is making the request is being treated or any facility in which the person resides;

☐ I am not directly involved in providing health care services to the person making the request; and

☐ I do not directly provide personal care to the person making the request.

Signature (Witness #1)	Date (yyyy/mm/dd)

Witness #2 Information

Last Name	First Name

Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number

ext.

By signing the below, I declare that:

☐ I am at least 18 years of age;

☐ I understand the nature of the request above 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;

☐ I am not an owner or operator of any health facility at which the person is making the request is being treated or any facility in which the person resides;

☐ I am not directly involved in providing health care services to the person making the request; and

☐ I do not directly provide personal care to the person making the request.

Signature (Witness #2)	Date (yyyy/mm/dd)