## Patient Request Section:

In this section, you are making a request for medical assistance in dying. You are required to initial the boxes on page 1 of the *Patient Request Form* next to the corresponding statement only if you agree with the statement. **Important: You must initial in the presence of the independent witnesses. See Independent Witnesses Section instructions in this document.**

**Proxy**

If you are physically unable to initial and sign the request form, you may have someone initial and sign for you. A proxy for medical assistance in dying cannot make decisions for you. The proxy must initial and sign in the required patient sections in your presence (in front of you) and under your direction. The proxy must also sign his or her name and complete the Declaration of Proxy on page 2 of the *Patient Request Form*.
**Important: The proxy cannot be one of the two independent witnesses.**

**Who can be a Proxy?**

- Must be at least 18 years of age
- Must understand the nature of the request for medical assistance in dying
- Not know or believe that they are a beneficiary in the will of the patient making the request
- Not know or believe that they are a recipient of financial or material benefit resulting from the patient's death

## Independent Witnesses Section:

**Independent witnesses must meet all of the following criteria:**

- Must be at least 18 years of age
- Must understand the nature of the request for medical assistance in dying
- Is personally known to the patient making the request and/or the patient has proof of identity
- Does not know or believe he or she is a beneficiary under the will of the patient, or a recipient, in any way of financial or material benefit resulting from the patient's death
- Is not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides
- Does not directly provide health care services or personal care to the patient

On page 2 of the *Patient Request Form*, under the "Confirmation of Independent Witnesses" section, the independent witnesses must initial beside the corresponding statement. They must also complete the signature section and provide the required information. This must be done in the presence of the patient making the request for medical assistance in dying.

The two independent witnesses should be present at the same time. If both witnesses are not able to be present at the same time you or your proxy will have to sign the *Patient Request Form* in the presence of each witness. This will result in your signature (or your proxy's signature) appearing twice on the bottom of page 1 of the *Patient Request Form*. The independent witnesses must also witness your signature (or your proxy's signature) on page 1. **Important: the ten day reflection period will start on the date the second witness signs** the *Patient Request Form*.

**Example 1: If the independent witnesses are present at the same time when you or your proxy sign:**

| Jane Doe | 01-Jan-2018 | J. Doe | Witness One | 01-Jan-2018 |
|---|---|---|---|---|
| Patient Name | Date | Signature of Patient | Signature of Independent Witness 1 | Date |
| | | | Witness two | 01-Jan-2018 |
| Patient Name | Date | Signature of Patient | Signature of Independent Witness 2 | Date |

**Example 2: If the independent witnesses <u>are not</u> both present at the same time when you or your proxy sign:**

| Jane Doe | 01-Jan-2018 | J. Doe | Witness One | 01-Jan-2018 |
|---|---|---|---|---|
| Patient Name | Date | Signature of Patient | Signature of Independent Witness 1 | Date |
| Jane Doe | 03-Jan-2018 | J. Doe | Witness two | 03-Jan-2018 |
| Patient Name | Date | Signature of Patient | Signature of Independent Witness 2 | Date |

**Where do I send the completed Patient Request Form?**
Once the request form is complete, please contact the Medical Assistance in Dying Program office at 204-926-1380. We can help decide how best to obtain the completed document.

If you have questions about medical assistance in dying or how to complete the *<u>Patient Request Form</u>* please contact the Medical Assistance in Dying Program at 204-926-1380 or maid@wrha.mb.ca

# Patient Request Form Medical Assistance in Dying (Manitoba)

**Tel: 204-926-1380**
**Fax: 204-940-8524**



*Please read this form carefully and feel free to ask any questions, now or at any time during your interactions with your health care providers. The physicians and staff from the Medical Assistance in Dying Program are here to assist you. This document shall form part of your health care record and will be retained in accordance with the policies and procedures of the applicable Regional Health Authority where you are receiving treatment and may be shared with regulatory authorities.*

## PATIENT INFORMATION

| Last Name | First Name | Second Name(s) |
|---|---|---|
| Personal Health Identification No.(PHIN) and/or Manitoba Health No. | Birthdate | Gender: ☐ Male ☐ Female ☐ Other - specify: |
| Patient's Home / Residence Address | | |
| Medical Diagnosis Relevant to Request for Medically Assisted Death | | |

## PATIENT REQUEST (must be completed in front of the independent witnesses as listed on page 2. A proxy may initial and sign for you if you are physically unable to. The proxy cannot be one of the independent witnesses and must meet the requirements set out in the Declaration of Proxy on page 2)

**By initialling and signing below, I confirm that:**

| | |
|---|---|
| Initials | I am eligible for health services funded by a government in Canada. |
| Initials | I am at least 18 years of age and I am capable of making decisions with respect to my health. |
| Initials | I request medical assistance in dying and I make this request voluntarily and without pressure from others. |
| Initials | I am informed that my medical condition is grievous and irremediable. |
| Initials | My medical condition causes me enduring suffering that is intolerable to me and which cannot be alleviated by any treatment acceptable to me. |
| Initials | I understand that the purpose and goal of requesting medical assistance in dying is to assist in bringing about my death. |
| Initials | I understand that, after I sign this request, I may change my mind at any time and in any manner and that I may withdraw my request for medical assistance in dying. |

**I certify that I have read and fully understand the above request to receive medical assistance in dying, and declare that I have voluntarily requested a medically assisted death and make this request free from external pressures.**

| Patient Name | Date | Signature of Patient | Signature of Independent Witness 1 | Date |
|---|---|---|---|---|
| Patient Name | Date | Signature of Patient | Signature of Independent Witness 2 | Date |

| Last Name of Patient | First Name of Patient | Second Name(s) of Patient |
|---|---|---|
| | | |

## DECLARATION OF PROXY (if applicable)

***If the patient requesting medical assistance in dying is physically unable to initial and sign, a proxy (another person) may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.***

**By initialling and signing below, I confirm that:**

| | |
|---|---|
| Initials | I am at least 18 years of age. |
| Initials | I understand the nature of the request for medical assistance in dying. |
| Initials | 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 the person's death. |
| Initials | I signed this request for medical assistance in dying in the presence of the person making the request, on his or her behalf and under his or her express direction. |

| Signature of Proxy | Print Name | Date Signed |
|---|---|---|
| Address | City / Province | Postal Code |

## CONFIRMATION OF INDEPENDENT WITNESSES

**By initialling and signing below, I confirm that:**

| Witness 1 | Witness 2 | |
|---|---|---|
| Initials | Initials | I am at least 18 years of age and understand the nature of the patient's request for medical assistance in dying. |
| Initials | Initials | The patient is personally known to me or has proof of identity. |
| Initials | Initials | The patient (or proxy, in the presence and at the express direction of the patient) signed this request in my presence. |
| Initials | Initials | I do not know or believe that I am a beneficiary under the will of the patient, or a recipient of a financial or material benefit resulting from the patient's death. |
| Initials | Initials | I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides. |
| Initials | Initials | I am not directly involved in providing health care services to the patient. |
| Initials | Initials | I do not directly provide personal care to the patient. |

## SIGNATURE OF INDEPENDENT WITNESSES

**WITNESS 1**

| Signature of Witness 1 | Print Name | Date Signed |
|---|---|---|
| Address | City / Province | Postal Code |

**WITNESS 2**

| Signature of Witness 2 | Print Name | Date Signed |
|---|---|---|
| Address | City / Province | Postal Code |

| Last Name of Patient | First Name of Patient | Second Name(s) of Patient |
|---|---|---|
| | | |

| **INFORMED CONSENT (to be signed only AFTER the first independent assessment has been completed)** | |
|---|---|
| **By initialling and signing below, I confirm that:** | |
| Initials | Further to my request for medical assistance in dying, I have discussed with a physician or nurse practitioner my diagnosis and prognosis, its nature and expected outcome, the potential complications of my medical condition and other related medical conditions, if applicable, including the treatments available for those conditions. |
| Initials | I have been informed by a physician or nurse practitioner about possible treatment options, as well as the options available to me to improve my suffering, including palliative care. |
| Initials | I have had the opportunity to discuss the process for and risks of medical assistance in dying, including the provision/administration of medications. |
| Initials | I understand that, if I no longer have the capacity to consent prior to the provision of medical assistance in dying, I will not receive medical assistance in dying, even if I have been previously deemed to be eligible to receive medical assistance in dying. |

| Patient Name | Date | Signature of Patient |
|---|---|---|

| **DECLARATION OF PROXY (if applicable)**<br>***If the patient requesting medical assistance in dying is physically unable to initial and sign, a proxy (another person) may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.*** | |
|---|---|
| **By initialling and signing below, I confirm that:** | |
| Initials | I am at least 18 years of age. |
| Initials | I understand the nature of the request for medical assistance in dying. |
| Initials | 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 the person's death. |
| Initials | I signed this request for medical assistance in dying in the presence of the person making the request, on his or her behalf and under his or her express direction. |

| Signature of Proxy | Print Name | Date Signed |
|---|---|---|
| Address | City / Province | Postal Code |