Medical Assistance in Dying
PATIENT REQUEST RECORD (Manitoba)

Please read this form carefully. Please feel free to ask any questions, now or at any time during your interactions with your health care providers. The physicians and staff at the Winnipeg Regional Health Authority 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 (YYYY/MM/DD)	Gender: ☐ Male ☐ Female ☐ Other - specify:
Patient's Home / Residence Address		
Medical Diagnosis Relevant to Request for Medically Assisted Death		

PATIENT REQUEST (must be initialled by patient or proxy in front of the two independent witnesses as listed on page 2)

If the patient requesting medical assistance in dying is physically unable to 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. *The proxy cannot be either of the witnesses listed on page 2. The proxy must be least 18 years of age, 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, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.* **See proxy signature box next page.**

By initialling and signing below, I confirm that:

Initials	I am at least 18 years of age. I am eligible for health services funded by a government of Canada.
Initials	I am capable of making decisions with respect to my health.
Initials	I request medical assistance in dying. 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.

PATIENT SIGNATURE FOR REQUEST (must be signed in front of two independent witnesses as listed on page 2)

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

Signature of Patient	Print Name	Date Signed

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

SIGNATURE OF PROXY (if applicable) **(must be signed in front of the patient and the two independent witnesses listed below)**		
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 (or proxy, in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other independent witness.
Initials	Initials	I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, 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 **(must be signed in the presence of the patient (and proxy if applicable) and the other independent witness)**		
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 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 SIGNATURE INDICATING INFORMED CONSENT		
Signature of Patient	Print Name	Date Signed

If the patient requesting medical assistance in dying is physically unable to 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. *The proxy cannot be either of the witnesses listed on page 2. The proxy must be someone who is at least 18 years of age, 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 patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.*

SIGNATURE OF PROXY (if applicable)		
Signature of Proxy	Print Name	Date Signed
Address	City / Province	Postal Code