Alberta Health Services

# WAIVER OF FINAL CONSENT
# For Medical Assistance in Dying

**(in accordance with section 241.2(3.2) of the *Criminal Code of Canada*).**
**The waiver of final consent is ONLY applicable for individuals whose natural death is reasonably foreseeable**

| **Patient Information (*"the Patient"*)** | | | |
|---|---|---|---|
| Last Name | First Name | Middle Name | |
| Date of Birth *(yyyy-mm-dd)* | Gender<br>☐ Male ☐ Female<br>☐ Other | Personal Health Number *(PHN)* | Postal Code |

| **Practitioner Information ("*the Practitioner"*)** | | |
|---|---|---|
| Last Name | First Name | Telephone Number |
| Designation<br>☐ MD ☐ NP | CPSA/CARNA Registration # | Agreed Date of MAID Provision<br>*(yyyy-mm-dd)* |

| **Declaration of Patient** |
|---|
| I, *the Patient*, have been informed by *the Practitioner* that I meet the eligibility criteria set out in section 241.2(1) of the *Criminal Code of Canada* and that all other safeguards set out in subsection (3) have been met |
| I, *the Patient* request that *the Practitioner*, provide me with medical assistance in dying on the Agreed Date of MAID Provision above. |
| I have been informed by *the Practitioner* of the risk of losing capacity to consent to receiving medical assistance in dying prior to the day specified in this agreement |
| I consent to receive medical assistance in dying on the Agreed Date of MAID Provision above even if I no longer have the capacity to consent to receiving medical assistance in dying on that date |
| I consent to the administration by *the Practitioner* of a substance to cause my death on or before the Agreed Date of MAID Provision above, if I lose the capacity to consent to receiving medical assistance in dying prior to that date. |
| I acknowledge that this agreement does not create any obligation for *the Practitioner to* administer me with MAID. *The Practitioner* may decide not to administer MAID under all circumstance. |

| Patient (Proxy) Initials | Practitioner Initials |
|---|---|
| | |

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| **Declaration of Practitioner** |
|---|
| *The Patient* meets the eligibility criteria out in section 241.2(1) of the *Criminal Code of Canada* and that all other safeguards set out in subsection (3) have been met |
| *The Patient has* requested that I provide them with medical assistance in dying on the Agreed Date of MAID Provision above. |
| I have informed *the Patient* of the risk of losing capacity to consent to receiving medical assistance in dying prior to the Agreed Date of MAID Provision above. |
| *The Patient* has given consent to receive medical assistance in dying on the Agreed Date of MAID Provision above, even if they no longer have the capacity to consent on that date. |
| *The Patient has* given consent to the administration by me of a substance to cause their death on or before the Agreed Date of MAID Provision above if they lose capacity to consent to receiving medical assistance in dying prior to that day. |
| I, *the Practitioner*, have agreed to provide medical assistance in dying to *the Patient on* the Agreed Date of MAID Provision above. |
| I have agreed to provide medical assistance in dying to *the Patient* on or before the Agreed Date of MAID Provision above, if *the Patient* loses their capacity to consent to receiving medical assistance in dying prior to the Agreed Date of MAID Provision above. |

**Additional Terms** *(Optional)*

The patient and practitioner may agree to additional terms of this agreement *(e.g. an alternate backup practitioner in event primary practitioner is unavailable, or specific condition or circumstances under which MAID could be provided on an earlier date)*. **NOTE:** Both the patient and practitioner must be in agreement and MAID must be provided in accordance with the terms of this agreement.

| Patient (Proxy) Initials | Practitioner Initials |
|---|---|
| | |

| **Additional Terms** *(continued)* |
|---|
| |

***To be completed by a Proxy only when then conditions for a Proxy are met.***

| Patient/Proxy Name | Date *(yyyy-mm-dd)* |
|---|---|
| Patient/Proxy Signature | |

| Practitioner Name | Date *(yyyy-mm-dd)* |
|---|---|
| Practitioner Signature | |

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**A proxy may sign for you if you are physically unable to sign the request. The proxy cannot be the same person as the Practitioner. The proxy must meet the requirements set out in the Declaration of Proxy.**

| **Declaration of Proxy** | |
|---|---|
| By initialing and signing below, I declare that: | |
| I am at least 18 years of age; and | |
| I understand the nature of the request for medical assistance in dying; and | |
| 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; and | |
| 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 informed consent. | |
| Proxy Name | Date *(yyyy-mm-dd)* |
| Proxy Signature | |
| Proxy Mailing Address | |
| Proxy Phone | |