

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 required information in the *Proxy Signature* sections.

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 will have to complete page 1 of the *Patient Request Form* in front of each witness. This will result in you completing page 1 of the *Patient Request Form* two times (once with each witness). **Important: the ten day reflection period will start on the date the second witness signs the *Patient Request Form*.**

Patient Request Form Medical Assistance in Dying (Manitoba)

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

Medical Assistance in Dying PATIENT REQUEST FORM Page 1 OF 3

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 will 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:
Patient's Home / Residence Address		
Medical Condition(s) Relevant to Request for Medically Assisted Death		

PATIENT REQUEST (must be completed in front of the independent witnesses as listed 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.

Signature of Patient	Print Name	Date Signed
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PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the two independent witnesses listed on page 2)

If the patient is unable to sign, a proxy (another person) may sign and initial on the patient's behalf and under the patient's express direction. The proxy cannot be either of the independent witnesses listed on page 2. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the patient's Will or a recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.

Signature of Proxy	Print Name
	Date Signed
	Phone Number

Address

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Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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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 patient's Will, 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

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Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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INFORMED CONSENT (to be completed only AFTER the first eligibility review 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, its nature and expected outcome, treatment options available and the potential complications of my medical condition(s).
Initials	I have been informed by a physician or nurse practitioner about 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.

Signature of Patient	Print Name	Date Signed
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PROXY SIGNATURE (IF APPLICABLE)

If the patient is unable to sign, a proxy (another person) may sign and initial on the patient's behalf and under the patient's express direction. The proxy cannot be either of the independent witnesses listed on page 2. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the patient's Will or a recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.

Signature of Proxy	Print Name
	Date Signed Phone Number

Address
