Santé et Services sociaux Québec

ADVANCE REQUEST MEDICAL AID IN DYING

Last Name

First Name

Date of Birth (Year Month Day)

Health Insurance N°

Expiration (Year Month)

Address

Postal Code

Telephone N° Area Code

1- Information on the diagnosis received by the person making the request (*Serious and incurable illness leading to incapacity to consent to care*)

Diagnosis

Date of diagnosis (Year Month Day)

Name of professional who made the diagnosis

Specify if necessary

2- Description by the person making the request of the clinical manifestations related to his or her illness that are to be considered, once he or she has become incapable of consenting to care and a qualified professional has ascertained that he or she has these manifestations, as an expression of his or her consent to medical aid in dying being administered to him or her once all the conditions stipulated by law have been met. (*Information from the person making the request*)

User Name	File N°

3- Medical description of the clinical manifestations described by the person making the request and to be considered as part of the follow-up to be given to the request. (*Information from the qualified professional*)

4- Compliance with the conditions relating to the clinical manifestations described by the person making the request. (*Section for the qualified professional*)

☐ *I have made sure, as a qualified professional, that the clinical manifestations described by the person making the request (see section 2) are medically recognized as possibly related to his or her illness and that they are observable by a qualified professional who would have to observe them before administering medical aid in dying.*

Specify if necessary

User Name	File N°

5- Signatures

Person making the request

I acknowledge that I have had the opportunity to speak with the people of my choice, among the professionals who treat or care for me, about my request.

I have been able to discuss my request with my loved ones or any other person with whom I have wished to do so.

I fully understand the possible course of my illness and I acknowledge that the possible alternatives to medical aid in dying have been presented to me, including possible therapeutic options and their consequences.

I acknowledge that the qualified professional has explained to me the conditions under which I will be able to receive medical assistance in dying, namely that:

- an anticipated request will not automatically lead to the administration of medical aid in dying;
- the recurrent presence of the clinical manifestations I have identified will not in itself allow me to receive medical assistance in dying;
- medical aid in dying may be administered only if, in addition to the other conditions stipulated in the law, two qualified professionals are of the opinion that I am experiencing persistent, unbearable physical or psychological suffering that cannot be alleviated under conditions deemed tolerable.

I acknowledge that the qualified professional has explained to me the possibility of withdrawing or modifying my request, as well as the terms and conditions applicable to such withdrawal or modification.

I have obtained answers to my questions, and I am making this request for medical assistance in dying in a free and informed manner, without external pressure.

Signature of the person	Year Month Day

Signature of authorized third party ☐ No authorized third party

(Optional: This section should be completed only if the person making the request is unable to write or date and sign on this form because he/she cannot write or is physically unable to do so, and a third party does so for him/her in his/her presence.)

First Name	Last Name

Signature	Year Month Day

User Name	File №

5- Signatures (cont'd)

Trusted Third Party(ies) Designated by the Person Making the Request ☐ no trusted third party

☐ **Trusted Third Party**

First Name	Last Name

Relationship with applicant

☐ **Second trusted third party appointed to replace the first if the latter has died, is prevented from fulfilling his role, refuses or neglects to do so.**

First Name	Last Name

Relationship with applicant

I understand my responsibilities as a trusted third party to notify a health or social services professional who provides care to the person making this advance request for medical assistance in dying, in any of the following situations:

- when the person has become unfit to consent to care, to inform or remind him or her of the existence of this request;
- when I believe that the person making the request has the clinical manifestations related to his or her illness and described in the request;
- when I believe that the person making the request is experiencing persistent and unbearable physical or psychological suffering.

Trusted third party signature	Year Month Day

Signature of second trusted third party	Year Month Day

User Name	File N°

5- Signatures (cont'd)

Witnesses ☐ Notarial Deed (no witnesses required)

The person making the anticipated request for medical assistance in dying has declared, in the presence of witnesses, that this form constitutes his or her anticipated request for medical assistance in dying.

Witness n° 1

First Name	Last Name

Signature — Year Month Day

Witness n° 2

First Name	Last Name

Signature — Year Month Day

Qualified Professional ☐ Md ☐ IPS

I am of the opinion that the person meets the following criteria to make an anticipated request for medical assistance in dying:

- the request is made in a free and informed manner and is not the result of external pressure;
- the person fully understands the nature of his or her diagnosis and has been informed of the possible course of the disease, the prognosis, possible therapeutic options and their consequences;
- the person has had the opportunity to talk to the members of the care team in regular contact with him/her, if applicable;
- the person has been given the opportunity to speak with his or her next of kin or any other person he or she has identified, if he or she so wishes;
- the person is deemed capable of consenting to care at the time of the request.

First Name	Last Name

Permit to Practice N°

Signature — Year Month Day