Health PEI
Provincial Medical Assistance in Dying Program (MAID)

Patient Label

Medical Assistance in Dying (MAiD)

Optional Assessment Form

Date/Time:		
Assessment:	☐ **1st Assessment**	☐ **2nd Assessment**
Location:		
People present:		
Other Assessor:		
Family MD/NP:		
Other consulting specialists:		
Integrated Palliative Care Program:		
Hospice services:		
Spiritual services:		
Counselling:		
Other community supports/groups:		

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History of presenting illness:

Past medical history:

Social history

Current living situation:
Marital status:
Children/dependents:
Other family:
Education:
Employment/retired:

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Any problems with venous access (IVs or bloodwork):		
Any current/past issues with alcohol or drug misuse:		
Weight (>250 lbs.):	☐ Yes	☐ No
Medication list:		
Allergies:		

MAiD Specific Questions

We are very interested in respecting any potential cultural factors that impact your care! Are there any cultural practices or beliefs that would be helpful for us to understand?
Are you passionate about any hobbies in particular?
Who is your proxy/SDM? What is their contact information?
Are there any relationship conflicts in your life that may impact your medical care or access to MAiD?
Do you feel that you have understood and have been included in medical decisions concerning your care up to this point?
Have you had any upsetting experiences along the journey of your healthcare experience?
Why MAiD?

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Why not palliative/natural death?
Are you aware of all treatment options?
Have you considered counselling to help you through this stressful time?
Is there anything that would change your mind about MAiD?
Have you had access to palliative care?
Are you aware of the process of approval for MAiD - Option for waiver of final consent (in case of high-risk capacity loss in setting of reasonably foreseeable natural death? - Waiting period 90 days (in case of not reasonably foreseeable natural death)
Have you thought about when and/or where you would like this to happen?
Have you thought about who you would like to be there at the time of MAiD?
Do you understand you can withdraw your request for MAiD at any time?
Do you have any questions about MAiD?
Would it be helpful for me to speak to anyone important for you about MAiD?
Any concerns about family/friends after you die?

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Do you have any thoughts about how we can support you through this process?
Advanced Care Planning:
Additional comments:

Assessment and Plan

HOPE Questions for Spiritual Assessment Appendix 1

Category	Sample Questions
H: sources of Hope	What are your sources of hope, strength, comfort, and peace?
O: organized religion	Are you part of a religious or spiritual community? Does it help you? How?
P: personal spirituality and practices	Do you have any personal spiritual beliefs? What aspects of your spirituality or your spiritual practices do you find most helpful? Does your current situation affect your ability to do things that usually help you spiritually?
E: effects on medical and end-of-life issues	As a doctor, is there anything I can do to help you access the resources that usually help you? Are there any specific practices or restrictions I should know about in providing your medical care? *If the patient is dying:* How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

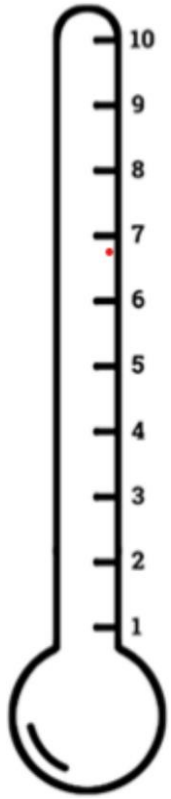
Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician. 2001;63(1):87

Additional comments:

Patient Label

Problem Checklist

Appendix 2

Canadian Problem Checklist		Distress Thermometer
Please check the following items that have been a concern or problem for your in the past week, including today		**Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week, including today**
Practical Problems • Work/School • Finances • Getting to/from appointments • Accommodations • Medication coverage	**Social** • Meaning/purpose of life • Faith	**Extreme Distress** 
Social/Family • Feeling a burden to others • Worry about friends/family • Feeling alone • Relationship difficulties	**Informational** • Understanding my illness and/or treatment • Talking with the health care team • Making treatment decisions • Knowing about available resources	
Emotional • Fears/worries • Sadness • Frustration/anger • Changes in appearance • Intimacy/sexuality	**Physical** • Concentration/memory • Sleep • Weight • Swallowing	
		No Distress
Discussion/Elaboration:		

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Edmonton Symptoms Assessment System Revised (ESAS-r)

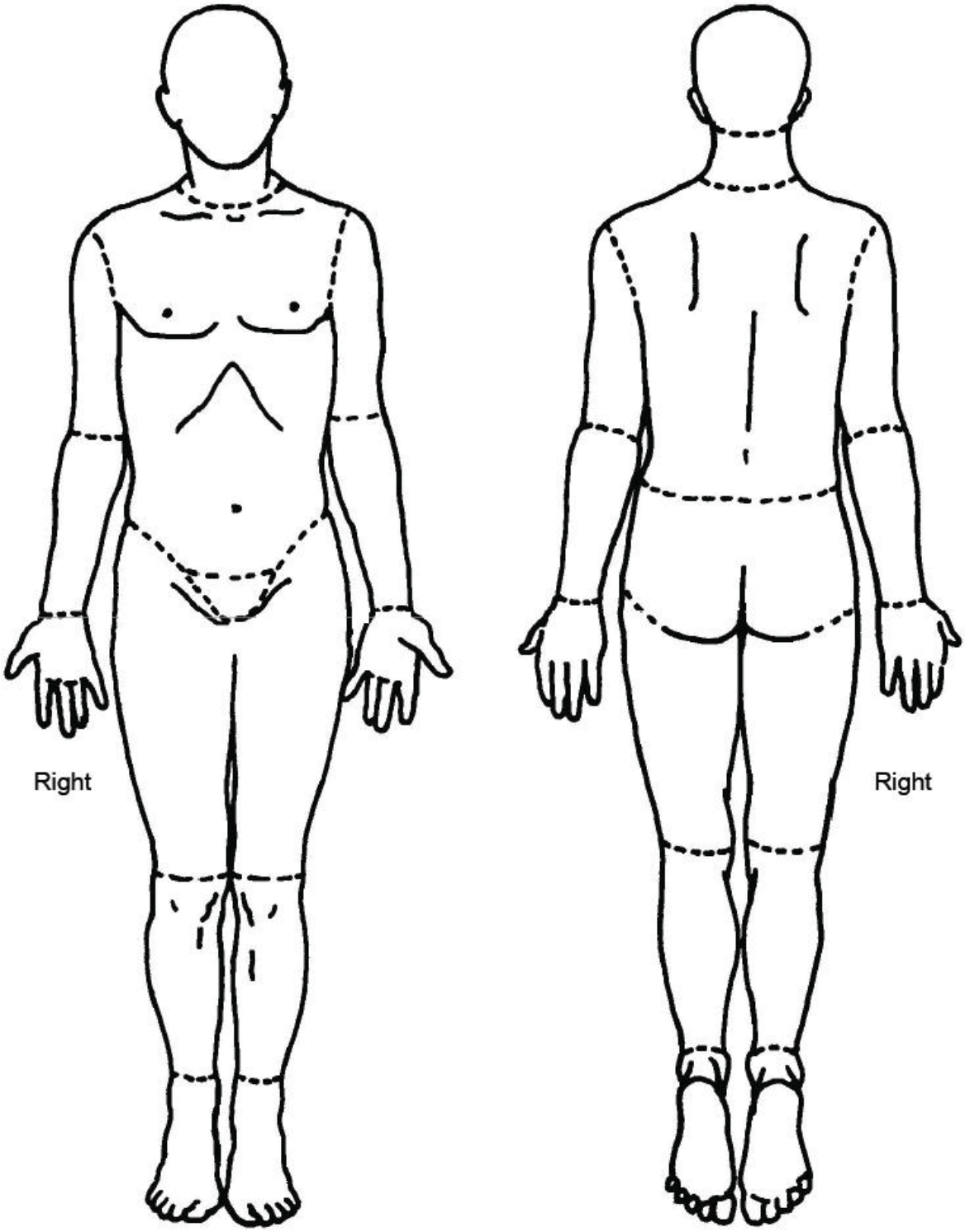
Appendix 3

Please circle the number that best describes how you feel **NOW**:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
Now Drowsiness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (ex constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient Name:	Completed by (check one) ☐ Patient ☐ Family Caregiver ☐ Health Professional Caregiver ☐ Caregiver-assisted **Body Diagram on Reverse**
Date (YYYY/MM/DD):	
Time (HH/MM):	

Patient Label



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Edmonton Frailty Scale (EFS)

Appendix 4

Frailty Domain	Item	0 Point	1 Point	2 Points
Cognition	Please imagine this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions, then place the hands to indicate a time of "ten after eleven".	**No errors**	**Minor spacing errors**	**Other errors**
General health status	In the past year, how many times have you been admitted to a hospital? In general, how would you describe your health?	**0** **Excellent/Very Good/Good**	**1-2** **Fair**	**>2** **Poor**
Functional independence	With how many of the following activities do you require help? Meal preparation Shopping Transportation Telephone Housekeeping Laundry Managing money Taking medication	**0-1**	**2-4**	**5-8**
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	**Always**	**Sometimes**	**Never**
Medication Use	Do you use five or more different prescription medications on a regular basis?	**No**	**Yes**	
	At times, do you forget to take your prescription medication?	**No**	**Yes**	
Nutrition	Have you recently lost weight such that your clothing has become looser?	**No**	**Yes**	
Mood	Do you often feel sad or depressed?	**No**	**Yes**	
Continence	Do you have a problem with losing control of urine when you don't want to?	**No**	**Yes**	
Self-Reported Performance	Two weeks ago, were you able to:			
	Do heavy work around the house like washing the windows, walls, or floors without help?	**Yes**	**No**	
	Walk up and down stairs to the second floor without help?	**Yes**	**No**	
	Walk 1km without help?	**Yes**	**No**	

Not Frail: 5 **Apparently Vulnerable: 6-7** **Mildly Frail: 8-9** **Moderate Frailty: 10-11** **Severe Frailty: 12-18**

Scoring for the Reported Frail Scale (___/18)

Patient Label

Assessment and Plan