MEDICAL ASSISTANCE IN DYING (MAID) PRESCRIPTION FORM HCCSS CENTRAL EAST

Bayshore Specialty Rx
233 Alden Road
Markham, ON L3R 3W6
T: 1-888-313-6988
F: 1-888-287-8577

Patient Name: _____ DOB: _____ /____ /_____

Health card: _____ Phone: _____ Alternate: _____

Address: _____ Province: _____

Allergies: _____

Deliver Medication to: _____

Deliver supplies to: _____

- **Scheduled Date and Time of Administration: _____**
- **Consent :**

Patient has given written consent to receive Medical Assistance in Dying and has met criteria to be eligible a) 18 years of age and older b) capable of making decisions with respect to their health c) has a grievous and irremediable medical condition and qualifies for health services funded by a government in Canada for Medical Assistance in Dying. I confirm that all safeguards have been met for patient to be eligible and to receive Medical Assistance in Dying.

Yes ☐ **No** ☐ Comments: _____

- **Kit Supplies:**

KIT 1	**3**-Chlorhexidine Swabstick 2% without Alcohol, **2**- 2 x 2" Gauze Pad, **2**-18Gx1.16"catheter, **2**-20G x1.16"catheter, **1**-22G x 1" Catheter, **2**-Extension Set Tubing 16", **2**-Neutral Displacement Connector, **2**-Tegaderm Dressing (6x7), **1**-Surgifix # 5.5 (1ft), **10**-18G x 1" Needle, **4**-10mL Syringe, **1**-3mL Syringe, **4**-60mL Syringe, **1**-20mL Syringe, **3**-Blue Pad, **4**-10mL Normal Saline Prefilled Syringe, **2**-Gloves (Med), **1**-Tourniquet (18"), **1**-Normal Saline 500mL, **1**-Continu-Flo 2-site
KIT 2	**Identical to Kit 1**
KIT 3	**1**-IV Hook, **1**-1.4L Sharps Container, **1**-Transpore Tape 1"

- **Flushing Guidelines for the Injection Device:**

Saline solution	**Total Quantity (divided into 2 kits)**	**Dosage**	**Special Instructions/ Comments**	Authorized Practitioner initials
NaCl 0.9%	**8** x 10mL	1 x 10mL IV to assess catheter patency at start of protocol 2 x 10mL IV after injecting the coma inducing agent 1 x 10mL IV after injecting the neuromuscular blocker		

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➢ Order of Administration:

Administration	Medication	Total Quantity Kit 1	Total Quantity Kit 2	Dosage	Special Instructions/ Comments	Authorized Practitioner Initials
STEP 1: ANXIOLYSIS (Benzodiazepine)	Midazolam **1mg/mL**	**10mg** 1 vial of 10mg/10mL	**10mg** 1 vial of 10mg/10mL	2.5 to 10mg (2.5 to 10mL) IV over 2minutes (To be titrated based on patient response)		
STEP 2a: COMA INDUCTION (Local anesthetic)	2% Lidocaine without epinephrine **20mg/mL**	**40mg** 1 Vial of 40mg/2mL	**40mg** 1 Vial of 40mg/2mL	40mg (2mL) IV over 30 seconds		
STEP 2b: **COMA INDUCTION (Coma-inducing agent)**	Propofol **10mg/mL**	**1000mg** 2 Vials of 500mg/50mL	**1000mg** 2 Vials of 500mg/50mL	1000mg(100mL) by slow IV injection (5 minutes) Use 2 syringes containing 500mg (50 mL) May repeat additional dose x 1 prn (Use Kit2) Shake before use	If an extra dose is needed please initial below *_____	
STEP 3: NEUROMUSCULAR BLOCKER (Muscle Relaxant)	Rocuronium bromide **10mg/mL**	**200mg** 4 Vials of 50mg/5mL	**200mg** 4 Vials of 50mg/5mL	**200mg**(20 mL) by rapid IV		

➢ Note for Authorized Practitioners:

- Lead time requirement for MAID orders: 48 hours on a regular business day
- Review the Medical Assistance in Dying medication administration protocol with the pharmacist.
- Return any unused medication or material as well as any empty packaging and syringes to the pharmacy once the medications have been administered.
- Medications will be numbered in the prescribed order of administration and placed in 2 identical kits.
- Unused medications will be picked up by Bayshore Specialty Rx after notification by Physician.
- Labels will be provided for syringe identification after Practitioner withdraws medication from vials.

❖ **This prescription has been completed following regulations of Bill C-14 Medical Assistance in Dying**

_____ _____ _____ _____

Authorized Practitioner Name **Signature** **_ CPSO#** **Date**

Please ensure form is complete for accuracy. **Kindly fax this form to 1-888-287-8577.**
For further information, do not hesitate to contact the BSRX Pharmacy team 1-888-313-6988.