Ontario Health atHome

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**Patient Identification**

Name: _____
Address: _____
City: _____ PC: _____
Phone: _____ DOB: _____
HCN: _____ VER: _____
BRN: _____

# Medical Assistance in Dying (MAiD) Referral Form - North Simcoe Muskoka

Ontario Health atHome MAiD Care Coordination service is providing this form to the Primary Care Provider to assist in the effective referral of a patient who has expressed interest in MAiD. Please complete the form as follows:

## Referral Information:

☐ Patient called MAiD Ontario Health atHome for a self-referral for MAiD

☐ Assessment **OR** I am referring this patient for MAiD Assessment

Name of referring Clinician: _____ Phone #: _____

Name of Family Doctor: _____ Phone #: _____

If referral is being requested by source other than Family Doctor, is Family Doctor aware of Referral? ☐ Yes ☐ No ☐ Unknown

Diagnosis contributing to MAiD request: _____

☐ The patient consented to sharing their health information in order to support their request.

**Does the patient meet the basic Eligibility Requirements below?**

- ☐ Has a valid health card # or proof of publicly funded insurance
- ☐ Is at least 18 years of age
- ☐ Has been informed they have a grievous and irremediable condition
- ☐ Is asking for MAiD voluntarily and not as a result of pressure from others
- ☐ Is giving consent to receive MAiD and has been informed of the means that are available to them to alleviate suffering including palliative care

Has palliative care been provided? ☐ Yes ☐ No ☐ Patient Declined

## Requested Service(s):

☐ I am seeking information about how to support my patient's request for MAiD

☐ Please provide this patient with information about MAiD

☐ Please provide this patient with MAiD assessment(s)

☐ I am willing to further support my patients request: ☐ As a MAiD assessor ☐ As a MAiD provider

☐ I am not willing to support as an assessor/provider for this referral. Please connect patient with assessor/provider.

## PLEASE SEND ANY RELEVANT INFORMATION THAT SUPPORTS THIS REQUEST:

- Relevant consult notes
- CPP (Diagnoses, investigations)
- Relevant Labs/Imaging
- Any recent corresponding medical information related to patient diagnosis

*** You may be contacted for further information**

Name (please print): _____ ☐ MD ☐ NP Other: _____

Phone # (private): _____ Physician Billing/CNO #: _____

Signature: _____ Date: _____

☐ I understand I will be contacted directly by assessors for this referral