

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: (Print first, last) _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

## Medical Assistance In Dying (MAiD) Referral Form

Please ensure this form is completed fully to avoid delays in the referral.

Email completed form to [maid@southlake.ca](mailto:maid@southlake.ca)

PATIENT INFORMATION	
Patient Name: (print last, first) _____	
Address: (including city and postal code) _____	
Patient Phone Number: _____	Health Card Number: _____
Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	Preferred Language of Service: _____
Name of Family Practitioner: _____	Phone Number: _____
REFERRAL INFORMATION	
Purpose of Referral: _____	<input type="checkbox"/> Request for information <input type="checkbox"/> Patient wants to initiate MAiD process
Primary Diagnosis: _____	
Is Palliative Care involved with the care of this patient: _____	<input type="checkbox"/> Yes Name: _____ <input type="checkbox"/> No
Alternate contact/Next of Kin: _____	Name: _____ Relationship: _____ Phone #: _____
Preferred place of provision: _____	<input type="checkbox"/> Home <input type="checkbox"/> Retirement or LTC <input type="checkbox"/> Hospital

If referral is being requested by source other than Family Practitioner, is Practitioner aware of referral?

- Yes  
 No  
 Patient consented to share their health information in order to support the request

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

- Relevant consult notes       Patients past medical history  
 Relevant labs       Recent corresponding medical information related to diagnosis

Name of Referring Clinician: _____ <input type="checkbox"/> MD <input type="checkbox"/> NP	
Phone Number: _____	CPSO/CNO #: _____
Date: <u>dd</u> / <u>mm</u> / <u>yy</u>	OHIP Billing #: _____
Signature: _____	

