HOME AND COMMUNITY CARE SUPPORT SERVICES
North Simcoe Muskoka
15 Sperling Drive, Suite 100
Barrie, ON L4M 6K9
Phone: 705-.721-8010
Toll Free: 1-888-721-2222
FAX: 705-792-6270
Toll Free: 1-866-700-1955

Patient Identification

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

Medical Assistance in Dying (MAiD) Referral Form

Home and Community Care NSM 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 NSMLHIN 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