Champlain Regional **Medical Assistance in Dying** (MAiD) Network | Réseau **d'aide médicale à mourir** (AMM) de la région de Champlain

Referral Form: Medical Assistance in Dying

1053 Carling Avenue,
Ottawa, K1Y 4E9 Box/C.P. 101
Fax (613) 761-4351

Patient Information:

Last Name, First Name:	
Address (including city and postal code):	
Telephone number:	
Health Card Number:	
Date of Birth:	
Gender:	
Preferred Official Language:	
Preferred Language of Service:	
Province of HCN:	
Where is the person currently located? If other, please specify:	

Referral Information:

Purpose of referral:	❑ Request for information ❑ Patient is ready to initiate MAiD process	
Did the patient mention when they would want MAiD?	❑ No Please specify:	❑ Yes
Primary diagnosis:		
Current function/ Summary of issues:		
Is Palliative Care involved with the care of this patient?	❑ No ❑ Unknown	❑ Yes ❑ N/A

I confirm:

A valid referral requires all items to be confirmed.

- ❑ The patient has a valid OHIP # or proof of publicly funded insurance.
- ❑ The patient is at least 18 years of age.
- ❑ The patient has capacity to understand their chronic health concerns and the risks and benefits of their treatment options to make an informed decision for MAiD.
- ❑ Mental health is not the sole source of suffering or reason for this referral.
- ❑ I will attach relevant documentation to support this referral.

Referring Clinician:

Referred by:	
Address:	
Fax number:	

Professional ID: ❑ MD ❑ NP ❑ Other, please specify:

- ❑ I am willing to support this patient's request as a MAiD assessor
- ❑ I am willing to support this patient's request as a MAiD Provider
- ❑ I would like more information about being a MAiD assessor or provider
- ❑ I do not wish to be a MAiD assessor/ provider for this referral

✕ ______________________________

Fax completed forms and supporting documentation to (613) 761-4351.

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