

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

I confirm:
 A valid referral requires all items to be confirmed.

<input type="checkbox"/> The patient has a valid OHIP # or proof of publicly funded insurance. <input type="checkbox"/> The patient is at least 18 years of age.	<input type="checkbox"/> 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.	<input type="checkbox"/> Mental health is not the sole source of suffering or reason for this referral. <input type="checkbox"/> I will attach relevant documentation to support this referral.
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Referring Clinician:			
Referred by:			
Address:			
Fax number:			
Professional ID: <input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> Other, please specify:			
<input type="checkbox"/> I am willing to support this patient's request as a MAiD assessor	<input type="checkbox"/> I am willing to support this patient's request as a MAiD Provider	<input type="checkbox"/> I would like more information about being a MAiD assessor or provider	<input type="checkbox"/> I do not wish to be a MAiD assessor/provider for this referral
X _____			