Ontario Health atHome
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

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

This communication is intended only for the party to whom it is addressed, and may contain information which is privileged or confidential. Any other delivery, distribution, copying or disclosure is strictly prohibited and is not a waiver of privilege or confidentiality. If you have received this telecommunication in error, please notify the sender immediately by telephone at 721-8010 or 1-888-721-2222 so that arrangements can be made for its destruction or return.