Ontario Health atHome

Medical Assistance in Dying (MAID) Services

Medical Referral and Attestation

The submission of this completed form for nursing and supplies facilitates the delivery of the MAID kit (i.e., supplies only and no medications) to the location you identify below, where the MAID procedure will take place.

Once complete, please fax to 613.745.8325. This is the Palliative Team's fax for MAID correspondence only and is monitored Mon – Fri, 0830-1630.

1) Patient Information		
Name		**Phone**
Street Address		
City		**Postal Code**
DOB	**OHIP**	**Version code**

2) Procedure Information		
Date and time		
Location	☐ Patient's residence	☐ Other (specify):

3) Confirmation of Fulfilled Requirements Please initial each completed requirement and provide the patient's diagnosis and relevant clinical history	**Initials**
a) Patient has a written and witnessed request for MAID in the form of Clinician Aid A	
b) Patient has been independently assessed by another provider who also found that they met the eligibility criteria for MAID	
c) Patient has provided informed consent to receive MAID	
d) Patient has given informed consent for their personal health information to be shared by email if faxing is not feasible	
e) I have assessed the patient and found them to meet the eligibility criteria for MAID, in which they have a grievous and irremediable medical condition.	
f) Patient's diagnosis and relevant clinical history:	

Ontario Health atHome

Patient Information	
Name	**DOB**

4) Order for Nursing			
☐ Nursing to insert two peripheral IVs	☐ Access central line	☐ Nursing presence required for procedure	☐ IV fluids to be started day before procedure
The College of Nurses of Ontario requires that written orders are received for nurses to start peripheral IVs for MAID. Fill in the box below for additional orders or supplies.			
Additional directions for nursing / Supplies (e.g. IV gauge)			

5) I confirm that I understand the following:	**Initials**
After the procedure, the prescriber must remove and return unused medication to the pharmacy in one of these ways: a) Arranging for immediate pick up with the pharmacy b) Taking medication with them for next-day pharmacy pick-up, or c) Returning it to the pharmacy themselves.	

6) Prescriber / Most Responsible Person (doctor or nurse practitioner)			
Name			
Signature			
Date			
Phone		**Email**	
Name of Coordinator / Social Worker (if applicable)			
Phone		**Email**	