Ontario
Waterloo Wellington Local Health Integration Network

141 Weber Street South
Waterloo, ON N2J 2A9
Phone(Intake): 519 883 5500
Fax(Intake): 519 883 5550
Toll Free Phone: 1 888 883 3313

Patient Information

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

Waterloo Wellington Medical Assistance in Dying (MAID) Referral Form

The WW Regional MAID Care Coordination Service (WWCCS) will begin to action this request within one business day and will complete the referral within a two week time frame. The requesting clinician will be contacted within one week with a status update.

Referral Information:

☐ Patient called MAID WWCCS/WWLHIN 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 OHIP # or proof of publically 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
- Relevant Labs/Imaging
- CPP (Diagnoses, investigations)
- 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.