SOUTH WEST LHIN MAiD REFERRAL

Phone: 1-833-388-7331 Fax: 1-833-388-7383 Email: sw.maid@lhins.on.ca

☐ MAID referral for someone not currently receiving SW LHIN services or unknown if they are receiving services
☐ MAID referral for someone currently receiving SW LHIN services

DATE OF REFERRAL:

REFERRAL SOURCE & DIRECT PHONE #:

PATIENT IDENTIFICATION

Patient Name:	DOB:	Phone #
Current Location:	HCN:	

Home Address:

CLINICAL INFORMATION

Diagnosis:

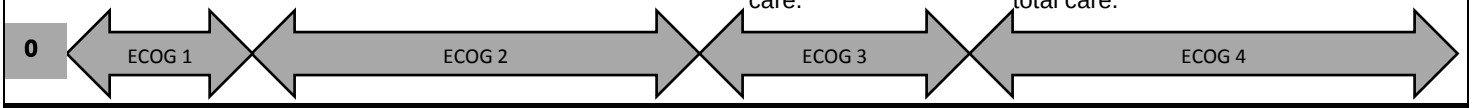
MAID PROGRESS (please check all that apply)

☐The patient has received high level information about MAID (what is MAID, steps in process etc.)
☐The patient has received a Form A Patient Request Form and instructions on how to fill it out
☐The patient has completed a Form A dated_____ and it is located _____
☐The patient has had/ will have a Form B assessment by whom: _____ when:_____
☐The patient has had/will have a Form C assessment by whom: _____ when:_____

FUNCTIONAL/PERFORMANCE STATUS:

PPS Level (ECOG):

☐ ≥ 80%	☐ 70%-60%	☐ 60%-50%	☐ 50%-40%	☐ 30%	☐ ≤ 20%
Normal activity, perhaps with some effort.	Full self-care to occasional assistance required.	Can no longer carry out normal work/hobby; normal or reduced intake.	Unable to do most activity; mainly in bed; extensive disease; normal or reduced intake; mainly assisted care.	Totally bed bound. Unable to do any activity; extensive disease; normal-reduced intake; total care.	Totally bed bound. Unable to do any activity; extensive disease; minimal intake; total care.



LOGISTICS

Is there an alternate contact person with whom we can book appointments and give information?

Who_____ Relationship _____ Phone _____

Has the patient indicated their preferred place of death? ☐ no ☐ yes, if so which is their preference

☐ private residence ☐ retirement or LTCH ☐ Hospital which one?_____

Does this patient have central venous access / PICC? ☐ yes ☐ no

Is the patient aware of this referral to the SW LHIN? ☐ yes ☐ no

Form Completed by: _____

****FAX COMPLETED FORM TO 1-833-388-7383**