

HOME AND COMMUNITY CARE SUPPORT SERVICES SOUTH WEST MAiD REFERRAL

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

<input type="checkbox"/> MAiD referral for someone not currently receiving HCCSS SW services or unknown if they are receiving services	
<input type="checkbox"/> MAiD referral for someone currently receiving HCCSS SW 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)	
<input type="checkbox"/> The patient has received high level information about MAiD (what is MAiD, steps in process etc.)	
<input type="checkbox"/> The patient has received a Form A Patient Request Form and instructions on how to fill it out	
<input type="checkbox"/> The patient has completed a Form A dated _____ and it is located _____	
<input type="checkbox"/> The patient has had/ will have a Form B assessment by whom: _____ when: _____	
<input type="checkbox"/> The patient has had/will have a Form C assessment by whom: _____ when: _____	
FUNCTIONAL/PERFORMANCE STATUS:	
PPS Level (ECOG):	
<input type="checkbox"/> ≥ 80% Normal activity, perhaps with some effort.	<input type="checkbox"/> 70%-60% Full self-care to occasional assistance required.
<input type="checkbox"/> 60%-50% Can no longer carry out normal work/hobby; normal or reduced intake.	<input type="checkbox"/> 50%-40% Unable to do most activity; mainly in bed; extensive disease; normal or reduced intake; mainly assisted care.
<input type="checkbox"/> 30% Totally bed bound. Unable to do any activity; extensive disease; normal-reduced intake; total care.	<input type="checkbox"/> ≤ 20% 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? <input type="checkbox"/> no <input type="checkbox"/> yes, if so which is their preference <input type="checkbox"/> private residence <input type="checkbox"/> retirement or LTCH <input type="checkbox"/> Hospital which one? _____	
Does this patient have central venous access / PICC? <input type="checkbox"/> yes <input type="checkbox"/> no	
Is the patient aware of this referral to the HCCSS SW? <input type="checkbox"/> yes <input type="checkbox"/> no	
Form Completed by: _____	
**FAX COMPLETED FORM TO 1-833-388-7383	