HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington
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 triage and prioritize each referral accordingly

Referral Information:

☐ Patient called MAID WWCCS for a self-referral for MAID Assessment **OR**
☐ I am referring this patient for MAID Assessment

Name of referring Clinician: _____ Phone #: _____
Secure email: _____
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 to support their request.

Does the patient meet the basic Eligibility Requirements below?

☐ Has a valid OHIP # 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 because 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):

☐ 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 new to MAID and interested in supporting this request with support from local MAID assessor

PLEASE SEND ANY RELEVANT INFORMATION THAT SUPPORTS THIS REQUEST:

- Relevant consult notes
- Relevant Labs/Imaging
- Completed clinician Aid A
- CPP (Diagnoses, investigations)
- Any recent corresponding medical information related to patient primary diagnosis
- Completed Clinician Aid C with MAID assessment narrative reference document

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.**