Ontario
Health atHome

MAiD Referral Form

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-833-388-7331 Fax: 519-657-0062 Email: sw.maid@hccontario.ca

Patient Information

Surname		First Name	
Home Address			
City		Postal Code	Date of Birth (DD-Month-YYYY)
Health Card Number	Version Code	Phone Number	
Current Location		Date Patient made request for assessment for MAiD (DD-Month-YYYY)	

Logistics

MAiD referral for someone not currently receiving Ontario Health atHome services or unknown if they are receiving services MAiD referral for someone currently receiving Ontario Health atHome services

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? Yes No, 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 OHaH? Yes No

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 Clinician Aid A Patient Request Form and instructions on how to fill it out

The patient has completed a Clinician Aid A dated: ________ and it is located: ______________________

The patient has had/will have a Clinician Aid B assessment by: ______________ when: ______________

The patient has had/will have a Clinician Aid C assessment by: ______________ 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	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.
0	ECOG 1	ECOG 2		ECOG 3	ECOG 4	

Referrer details

Referrer Name	CPSO/CNO Registration Number	Date
Signature	Phone Number	Fax completed form to **519-657-0062**