



MEDICAL ASSISTANCE IN DYING TRANSFER OF REQUEST



DRDR107165A

(HLTH 1642) New: Oct 30/18

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The transferring practitioner is to fax this form to the Ministry of Health at 778-698-4678 within 30 days after the day on which the practitioner transferred the patient's written request to MAiD. Retain original in patient's health record.

PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN) <input type="checkbox"/> N/A	Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:		
Province or Territory that Issued PHN <i>If patient does not have a PHN, provide the province or territory of patients usual place of residence</i>			Postal Code Associated With PHN <i>If patient does not have a PHN, provide the postal code of patients usual place of residence</i>		

PRACTITIONER INFORMATION

Last Name		First Name		Second Name	
<input type="checkbox"/> CPSID # <input type="checkbox"/> BCCNP Prescriber #	Phone Number		Fax Number		Work Email Address
Work Mailing Address				City	Postal Code
If you are a physician, what is your area of specialty? <input type="checkbox"/> Anaesthesiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Family medicine <input type="checkbox"/> General internal medicine <input type="checkbox"/> Geriatric medicine <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Palliative medicine <input type="checkbox"/> Respiratory medicine <input type="checkbox"/> Other - specify:					

RECEIPT OF WRITTEN REQUEST

Date written request received (YYYY / MM / DD)	Province or Territory where you received the written request for MAiD
To the best of your knowledge or belief, before you received the written request for MAiD, did the patient consult you concerning their health for a reason other than seeking MAiD? <input type="checkbox"/> Yes <input type="checkbox"/> No	
From whom did you receive the written request for MAiD that triggered the obligation to provide information? <input type="checkbox"/> Another practitioner <input type="checkbox"/> Patient directly (1632 form) <input type="checkbox"/> Patient directly - other, specify: _____ <input type="checkbox"/> MAiD Care coordination service <input type="checkbox"/> Another third-party - specify: _____	

TRANSFER OF REQUEST

Date of transfer of request or care (YYYY / MM / DD)	Did you complete an eligibility assessment prior to transfer of request or care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, was the patient eligible for MAiD in your opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you transfer the request or care for any of the following reasons (select all that apply): <input type="checkbox"/> Due to policies on MAiD of a hospital, community care facility or palliative care facility where the patient is located <input type="checkbox"/> Due to lack of relevant expertise to provide MAiD <input type="checkbox"/> The facility would not permit MAiD assessment on site <input type="checkbox"/> Due to lack of relevant expertise to assess for MAiD <input type="checkbox"/> The facility would not permit MAiD provision on site <input type="checkbox"/> Due to patient's request <input type="checkbox"/> Assessing or providing MAiD is contrary to your conscience or beliefs <input type="checkbox"/> None of the above <input type="checkbox"/> Other -specify: _____		
Where did you transfer the request or care to? (i.e. where did you send the patient's written request?) <input type="checkbox"/> Another Practitioner <input type="checkbox"/> MAiD Care Coordination Service (contact info below) <input type="checkbox"/> Other- specify: _____		
Practitioner Signature		Date (YYYY / MM / DD)

Health Authority fax numbers for submission of forms:
Fraser HA: Fax: 604-523-8855 **Northern HA:** Fax: 250-565-2640 **Vancouver Island HA:** Fax: 250-727-4335
Interior HA: Fax: 250-469-7066 **Vancouver Coastal HA:** Fax: 1-888-865-2941 **Provincial Health Services Authority:** Fax: 604-829-2631
 For mailing addresses, see:
<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms>

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