



West Coast

- ASSISTED DYING -

www.westcoastad.ca info@westcoastad.ca

PHONE 778 265 9224 FAX 250 480 7339

REFERRAL FORM

URGENT NON URGENT

Must be included with Referral

- Patient Request Record
- Assessment (Assessor) Record (if no, please refer to VIHA MAiD Fax: 250 727 4335)
- Clinical Records (pertinent patient history)

Referring Clinician: _____ MSP# _____

Phone # _____ Fax# _____

Family Physician (if different from referring GP): Dr. _____

Patient Name: _____

DOB: _____

PHN: _____

Address: _____

Phone: _____



Main Contact: _____ Phone#: _____

Location of Patient: home hospital hospice other _____

Primary Diagnosis: _____

Pertinent Patient Details eg. Non-Verbal best contacted through family member:

The information contained in this transmission is intended solely for the use of the individual to whom it is addressed, and contains information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, copying or disclosure of this communication is strictly prohibited. If you have received this message in error, please notify us immediately by telephone and destroy this fax. Thank you.

West Coast Assisted Dying (WCAD) respects and upholds an individual's right to privacy and the protection of his or her personal information. **WCAD** is committed to ensuring compliance with the **Personal Information Protection Act – Bill 38**.