West Coast
- ASSISTED DYING -

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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: _____

PATIENT LABEL

Main Contact: _____ Phone#: _____

Location of Patient: □ home □ hospital □ hospice □ other _____

Primary Diagnosis: _____

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

_____

_____