West Coast
- ASSISTED DYING -

www.westcoastad.ca info@westcoastad.ca
PHONE 778 265 9224 **FAX** 250 480 7339

REFERRAL FORM

Referring Dr. ______________________________________ MSP# ______________________

Ph #_____________________________________ Fax#_______________________

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

Would you be willing to be the 2nd assessor for this patient? **□ yes □ no**

Patient Name: __________________________________

DOB: ____________________________________

PHN: ____________________________________

Address: _________________________________

Phone: __________________________________

PATIENT LABEL

LEGAL Next of Kin: _____________________________ PH#: ___________________________________

Other Contacts: _______________________________ PH#: ______________________________________

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

NON URGENT: □ **URGENT: □**

Please advise your patient we will be in contact within a few days

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Primary Diagnosis: ____

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

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Please send all pertinent patient history along with this referral

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