



Medical Assistance in Dying
TRANSFER OF REQUEST

HLTH 1642

Patient Label

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 for MAiD. Retain original in patient's health record.

1. PATIENT INFORMATION

Form section for patient information including Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Sex, Province or Territory that Issued PHN, and Postal Code Associated With PHN.

2. PRACTITIONER INFORMATION

Form section for practitioner information including Last Name, First Name, Second Name, CPSID #, BCCNM #, Phone Number, Fax Number, Work Email Address, Work Mailing Address, City, and Postal Code.

Form section for physician specialty including checkboxes for Anaesthesiology, Cardiology, Family medicine, General internal medicine, Geriatric medicine, Nephrology, Neurology, Oncology, Palliative medicine, Respiratory medicine, and Other - specify.

3. RECEIPT OF WRITTEN REQUEST FOR MAiD

Form section for receipt of written request for MAiD including I received the patient's written request for MAiD, From whom did you receive the written request for MAiD, and Date Written Request Received.

Form section for consultation and province/territory where received including 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? and Province or Territory where you received the written request for MAiD.

4. TRANSFER OF REQUEST

Form section for transfer of request including Date of transfer of request or care, Did you complete an eligibility assessment prior to transfer of request or care?, and If Yes, was the patient eligible for MAiD in your opinion?

Form section for reasons for transfer including Did you transfer the request or care for any of the following reasons (select all that apply): Due to policies on MAiD of a hospital, community care facility or palliative care facility where the patient is located, Due to lack of relevant expertise to provide MAiD, etc.

Form section for transfer location including Where did you transfer the request or care to? (i.e. where did you send the patient's written request?)

Form section for practitioner signature including Practitioner Signature and Date (YYYY / MM / DD).

Health Authority fax numbers for submission of forms: Fraser HA: Fax: 604-523-8855, mccc@fraserhealth.ca; Vancouver Coastal HA: Fax: 1-888-865-2941, AssistedDying@vch.ca; Vancouver Island HA: Fax: 250-519-3669, maid@islandhealth.ca; Northern HA: Fax: 250-565-2640, maid@northernhealth.ca; Provincial Health Services Authority: Fax: 604-829-2631, maiddco@phsa.ca