NSH MEDICAL ASSISTANCE IN DYING (MAID) REFERRAL FORM

Fax Referral to: 902−454−0379 Phone Number: 902−491−5892 Email: MAID@nshealth.ca

Patient Name: _____ **Date of Birth:** _____ (YYYY/MON/DD)

Health Card: _____

Current Location: ❑ Home ❑ Hospital ❑ LTC

Home Address: _____

_____

Phone: _____

Alternate Phone: _____

Alternate Contact Person: _____

Relationship: _____

Phone: _____

Aware of this referral: ❑ Yes ❑ No

Family Physician / Nurse Practitioner: _____

_____

Aware of this referral: ❑ Yes ❑ No

Diagnosis

Diagnosis resulting in MAID request:

_____

_____

Date of Diagnosis: _____ (YYYY/MON/DD)

Estimated Prognosis: ❑ Less than 1 week
❑ Less than 1 month ❑ Less than 6 months
❑ Greater than 6 months ❑ Unsure

Palliative Performance Scale Score (optional):

_____

Other health issues: _____

_____

_____

Followed by Palliative Care: ❑ Yes ❑ No ❑ Unsure

Code Status Addressed: ❑ Yes ❑ No

Status: _____

Personal Directive: ❑ Yes ❑ No ❑ Unsure

Name of SDM: _____

Goals for MAID

❑ Assessments for MAID Procedure ASAP
❑ Assessments for Procedure at a later date

Notes: _____

_____

Are you concerned patient may lose capacity to consent to MAID in the near future? ❑ Yes ❑ No

Notes: _____

_____

MAID Documents (not required for MAID referral)

Patient has been given a copy of the relevant College Standard on MAID ❑ Yes ❑ No

Patient has been given a MAID Consent Form ❑ Yes ❑ No

Referring Clinician Involvement

Consult letter attached detailing relevant clinical information ❑ Yes ❑ No

I would like to learn more about the MAID Assessment process ❑ Yes ❑ No

Other Notes

Referring Clinician: _____ **Contact Number:** _____

Signature: _____ **Date (YYYY/MON/DD):** _____