



Medical Assistance in Dying TRANSFER OF REQUEST

HLTH 1642 2018/10/30

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.

PATIENT INFORMATION

Form section for Patient Information including Last Name, First Name, Second Name(s), Personal Health Number (PHN), Birthdate, Gender, and Postal Code.

PRACTITIONER INFORMATION

Form section for Practitioner Information including Last Name, First Name, Second Name, CPSID #, BCCNP Prescriber #, Phone Number, Fax Number, Work Email Address, Work Mailing Address, City, and Postal Code.

Form section for physician specialty: If you are a physician, what is your area of specialty? (Anaesthesiology, Cardiology, Family medicine, General internal medicine, Geriatric medicine, Nephrology, Neurology, Oncology, Palliative medicine, Respiratory medicine, Other - specify)

RECEIPT OF WRITTEN REQUEST

Form section for Receipt of Written Request including Date written request received and Province or Territory where you received the written request for MAiD.

Form section: 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? (Yes/No)

Form section: From whom did you receive the written request for MAiD that triggered the obligation to provide information? (Another practitioner, Patient directly, MAiD Care coordination service, etc.)

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: Did you transfer the request or care for any of the following reasons (select all that apply): (Due to policies on MAiD, Due to lack of relevant expertise, etc.)

Form section: Where did you transfer the request or care to? (i.e. where did you send the patient's written request?) (Another Practitioner, MAiD Care Coordination Service, etc.)

Form section for Practitioner Signature and Date (YYYY / MM / DD)

Health Authority fax numbers for submission of forms: Fraser HA, Northern HA, Vancouver Island HA, Interior HA, Vancouver Coastal HA, Provincial Health Services Authority. For mailing addresses, see: https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms

This information is collected by the Ministry of Health under s.26(c) of the Freedom of Information and Protection of Privacy Act (FOIPP Act) and will be used for the purposes of monitoring and oversight for the provision of Medical Assistance in Dying in British Columbia.