BRITISH COLUMBIA | Ministry of Health

1642
2022/02/25

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

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Birthdate (YYYY / MM / DD)	Sex ◯ Male ◯ X (specify) ◯ Female

Province or Territory that Issued PHN *If patient does not have a PHN, provide the province or territory of patient's usual place of residence*	Postal Code Associated With PHN *If patient does not have a PHN, provide the postal code of patient's usual place of residence*

2. PRACTITIONER INFORMATION

Last Name	First Name	Second Name

◯ CPSID # ◯ BCCNM #	Phone Number	Fax Number	Work Email Address

Work Mailing Address	City	Postal Code

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:

3. RECEIPT OF WRITTEN REQUEST FOR MAiD

I received the patient's written request for MAiD

◯ Yes ◯ No

If Yes, complete all of Section 3

Date Written Request Received (YYYY / MM / DD)

From whom did you receive the written request for MAiD?

◯ Patient directly (1632 form) ◯ Patient directly - other, specify: ◯ Another third-party - specify:
◯ Another practitioner
◯ MAiD Care coordination service

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

Province or Territory where you received the written request for MAiD

4. TRANSFER OF REQUEST

Date of transfer of request or care (YYYY / MM / DD)	Did you complete an eligibility assessment prior to transfer of request or care? ◯ Yes ◯ No	If Yes, was the patient eligible for MAiD in your opinion? ◯ Yes ◯ No

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
☐ The facility would not permit MAiD assessment on site
☐ The facility would not permit MAiD provision on site
☐ Assessing or providing MAiD is contrary to your conscience or beliefs
☐ Due to lack of relevant expertise to *provide* MAiD
☐ Due to lack of relevant expertise to *assess* for MAiD
☐ Due to patient's request
☐ None of the above - specify:

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 (contact info below) ◯ Other- specify:

Practitioner Signature	Date (YYYY / MM / DD)

Health Authority fax numbers for submission of forms:

Fraser HA: Fax: 604-523-8855, mccc@fraserhealth.ca
Interior HA: Fax: 250-469-7066, maid@interiorhealth.ca
Northern HA: Fax: 250-565-2640, maid@northernhealth.ca
Vancouver Coastal HA: Fax: 1-888-865-2941, AssistedDying@vch.ca
Vancouver Island HA: Fax: 250-519-3669, maid@islandhealth.ca
Provincial Health Services Authority: Fax: 604-829-2631, maidcco@phsa.ca

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. Should you have any questions about the collection of this personal information, please contact the Manager, Medical Assistance in Dying Oversight Unit at PO BOX 9638 STN PROV GOVT, Victoria BC V8W 9P1; 236-478-1915

Save Print Clear Form