Health PEI
Provincial Medical Assistance in Dying (MAiD) Program

Patient Label

Medical Assistance in Dying (MAiD)
Clinic Referral Form

Date of Referral/Request: _____

Urgency: ☐ 1 Week ☐ 2-4 Weeks ☐ 2-3 Months

Referral Source ☐ MD ☐ NP ☐ Specialist ☐ Patient

Reason for Referral/Request: ☐ Formal MAiD Assessment ☐ Information/Education

Medical Condition/Diagnosis causing request for MAiD: _____

Patient Address:

Phone:

Email:

Preferred Contact & Details:

Is the patient currently known to the Provincial Integrated Palliative Care and/or Provincial Home Care support programs:

☐ Yes-Which team?_____ ☐ No

History of Present Illness/Brief Health History (relevant to request):

Other relevant information:

☐ **Patient completed Request & Consent Form today & faxed to Provincial MAiD Program**
☐ **Patient given Request & Consent Form & will complete and send within next 5 days**

Please submit completed form via fax to 1-833-704-1891 or e-mail pmc@ihis.org

Referral Source: _____ **Signature:** _____

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