[Patient Label]

Health PEI

Home Care IV Insertion Order Form for Medical Assistance in Dying (MAiD)

Phone: 902-288-1260 **Fax:** 1-833-704-1891 **Email:** pmc@ihis.org **Office Hours:** Mon.-Fri. 8AM–4PM

FAX TO:

☐ Queens: 902-368-4858 ☐ West Prince: 902-859-8701

☐ East Prince: 902-888-8439 ☐ Montague: 902-838-0774 ☐ Souris: 902-687-7048

Client Name	Last:	First:	Middle:
PHN:		DOB:	Phone:
Address:	Street/Apt:	City:	Postal Code:
Ordering Physician/NP	Name:	Phone:	Fax:
Primary Care Physician/NP	Name:	Phone:	Fax:

This patient is an active HC client. ❑ Yes ❑ No

This patient has been assessed and found eligible for MAiD.

Plan for MAiD Procedure on _____ (date) at _____ (time).

☐ Please start **two 20 or 22** gauge peripheral IVs (or largest possible), **one in each arm/ACF (not the hand).**
Preferred date/time for IV insertion: _____

Please inform ordering provider if there are any issues with IV insertion or quality of IV access.

OR

☐ Please access patient's port-a-cath or flush to verify patency of PICC line.
(Preferred date/time for line access: _____)

The patient has a **Waiver of Final Consent.** ☐ YES Expires: _____ ☐ NO

Please ensure orders are fully complete and accurate. Incomplete orders cannot be processed and will be returned to prescriber.

Referring MD Signature: **Contact #:** **Date :**