Medical Assistance in Dying (MAiD)

Patient Self-Referral Form

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| This form is for people who wish to apply for Medical Assistance In Dying (MAiD) but whose own physician is unable to make a referral for MAiD due to conscientious objection. We strongly advise that if you have not already discussed End of Life issues with your family physician that you do so before sending us this form. Send the completed form either to Dr Tanja Daws, Fax 250 334 2642, Tel 250 334 2445 or to Dr Jonathan Reggler, Fax 250 338 1245, Tel 250 334 4411 |

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| YOUR INFORMATION |
| Name: |  | Date of Birth: |  |
| **Personal Health Number:** (On your BC Care Care/ Services BC Card |  \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ |
| Address: |  |
|  |
| Home phone number: |  | Cell phone number: |  |
| FAMILY PHYSICIAN DETAILS |
| Name: |  |
| Address: |  |
|  |
| Office phone number: |  |
|  |
| Diagnosis: |  |
| MAiD |
| Have you discussed End of Life issues with your Family Physician? | Yes No |
| Have you discussed MAiD with your Family Physician? | Yes No |
|  |
| Are you seeking MAiD? | Yes No |
| Are you seeking additional information about all End of Life options? | Yes No |
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| Do you consent to one of the MAiD physicians contacting your Family Physician about your application? | Yes No |

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| Signature: |  |
| Date: |  |