Shared health Soins communs Manitoba

Medical Assistance in Dying (MAiD) Contact Form

Phone: 204- 926-1380 | Fax 204-940-8524 | Email: maid@sharedhealthmb.ca

Submitting Clinician/Program: _____ **Date:** _____

Contact number: _____ **Fax:** _____

Patient Information

Patient name: _____ Date of birth: _____

Contact number: _____ PHIN: _____ MHSC#: _____

Current location: ☐ Home ☐ Hospital ☐ LTC ☐ Other Please specify: _____

Address: _____ City: _____ Postal code: _____

Primary language of communication: _____ Other languages: _____

Interpreter needed: ☐ Yes ☐ No

Alternate contact: _____ Relationship: _____ Phone: _____

Is the alternate contact aware? ☐ Yes ☐ No

Primary Care provider: _____ Phone: _____ Fax: _____

Clinical Information

Diagnosis resulting in MAiD request:

Date of Diagnosis (if known): _____

Estimated Prognosis: ☐ < Less than 1 month ☐ 1 to 6 months ☐ > 6 months ☐ Unsure

Are you concerned patient may lose capacity to consent to MAiD in the near future? ☐ Yes ☐ No

Other health issues:

Functional/Performance Status

☐ Normal Activity

☐ Can care for self with occasional assistance

☐ Can no longer carry out normal work/hobby- need assistance 50-60% time

☐ Chair or bed bound, needs considerable amount of assistance

☐ Total care; unable to do any activity

Goals for MAiD

☐ Assessment for MAiD Procedure ASAP ☐ Assessment for MAiD Procedure at a later date

☐ Information Only

☐ Other:

Please attach any other relevant information

Updated: Feb. 2024