Referral Form -
Practitioner Refers or Transfers the Care of a Patient in Response to a Written Request

Section 1: Basic Information

1a. Patient Information

Last Name	First Name	Middle Name

Date of birth (YYYY/MM/DD)	Sex □ Male □ Female □ Other	Health services number □ Not applicable

Province or territory that issued the health services number *If the patient does not have a health services number, please indicate the province or territory of their usual place of residence on the day the practitioner received the written request.*	Postal code associated with the patient's health services number *If the patient does not have a health services number, please indicate the postal code of their usual place of residence on the day the practitioner received the written request.*

1b. Practitioner Information

Last Name	First Name	Middle Name	Phone Number ( )

Mailing Address at your primary place of work (Street Number, Name, City, and Postal Code):

Work e-mail address:

Province or territory of practice (and within which the written request was received):

Are you a (choose one): □ Physician □ Nurse practitioner	If you are a physician, what is your area of specialty: □ Anesthesiology □ Cardiology □ Family medicine □ General internal medicine □ Geriatric medicine □ Nephrology □ Neurology □ Oncology □ Palliative medicine □ Respiratory medicine □ Psychiatry □ Other - specify:	Licence or registration number *If you practice in more than one province or territory, please indicate the licence or registration number for the province or territory in which you received the written request for MAID. This number is the one attributed to you by your College, not your billing number.* 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 □

1c. Receipt of the Written Request

From whom did you receive the written request for MAID that triggered the obligation to provide information? □ Patient directly □ Another practitioner □ Care coordination service □ Another third party- specify:	Date of receipt of written request for MAID (YYYY/MM/DD)

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Section 2: Referring or Transferring the Care of a Patient *Only complete this section if you are providing information about a referral or a transfer of care that is the result of a MAID request.*	
Date of referral or transfer of care (YYYY/MM/DD)	Did you complete an eligibility assessment prior to referring the patient or transferring their care? □ Yes □ No **If yes**, was the patient eligible for MAID, in your opinion? □ Yes □ No
Did you refer the patient elsewhere or transfer their care for any of the following reasons (select all that apply): □ Due to policies on MAID of a hospital, residential care facility or palliative care facility where the patient is located □ Assessing or providing MAID is contrary to your conscience or beliefs □ Due to lack of relevant expertise to provide MAID □ Due to patient's request OR □ None of the above	
Supplementary Information (Please include any additional comments on the above information)	

PLEASE NOTE: the 'Referring or Transferring the Care of a Patient' section above is a reporting requirement of the federal government.

*The Saskatchewan Health Authority is named in the federal regulations as a provincial designate. This form must be faxed to 1-833-837-9006 within federally required timelines.
* If you have any questions about the completion of this form or reporting obligations, please call the SK Health Authority at 1-833-473-6242.