Organ/Tissue Donation after MAiD Referral

BC TRANSPLANT
Suite 260- 1770 West 7th Avenue
Vancouver, BC V6J 4Y9
Tel: (604) 877-2240

FAX OR EMAIL REFERRAL FORMS TO 604-708-2764 / BCTmaidreferrals@phsa.ca

REFERRALS CAN BE SUBMITTED BY MD/NP/RN/MAID COORDINATOR

IF MAID PROVISION IS LESS THAN 10 DAYS FROM REFERRAL DATE, CALL 1-877-DONOR-BC AND DO NOT FAX

Referral Date (DD-MM-YYYY)

PATIENT CONTACT INFORMATION

Last name: First name: DOB (DD-MM-YYYY):

◯ Male ◯ Female BC PHN: Other PHN:

Height (cm, if known) : Weight (kg, if known):

◯ English Speaker ◯ Other Language: ☐ Translator Needed ☐ Non-Verbal

Address: City: Province: Postal Code:

Home Phone: Cell Phone: Email:

CAREGIVER/SUPPORT PERSON:

Name: Home Phone: Cell Phone: Relationship to patient:

REFERRING PERSON:

Name: Phone: Fax: Relationship to patient:

FAMILY PHYSICIAN:

Name: Phone: Fax:

Has your patient been approved for MAiD by 2 assessors? ◯ Yes ◯ No

NOTE: BCT requires both assessments completed before referral for organ donation.

Anticipated provision date (MM-YYYY):

No anticipated date set ☐

I confirm my patient **DOES NOT** meet the exclusion criteria for organ donation (see across). ☐

I confirm my patient **DOES NOT** meet the exclusion criteria for eye donation (see across). ☐

Underlying reason/diagnosis for seeking MAiD:

Does the patient have a hospital preference for provision? ◯ Yes: ◯ No preference

Additional comments:

ORGAN DONATION EXCLUSION CRITERIA

- HIV
- >80 YEARS OLD
- METASTATIC CANCER

EYE DONATION EXCLUSION CRITERIA

- ALS
- MULTIPLE SCLEROSIS
- ALZHEIMERS
- PARKINSONS
- >75 YEARS OLD