□ Maison Mathieu Forment Savoie 170 Rue Sherbrooke, Gatineau, QC J8Y 2L6 Tel: 819-770-3900 Fax. : 819-770-7264 soins@mmfs.org □ Résidence Le Monarque 41 Chem. des Presqu'îles, Plaisance, QC J0V 1S0 Tel: 819-308-0899 Fax. : 819-308-0777 soins@residencelemonarque.com □ La Maison des Collines 99 Chem. Burnside, Wakefield, QC J0X 3G0 Tel: 819-459-1233 Fax. : 819-459-1568 soins@lamaisondescollines.org	**Request for services in palliative care home** _____ (YY/MM/DD) □ End-of-life admission □ Pre-admission request □ Respite admission (MMFS and MDC) □ Request for planned short stay (AMM / MMFS)

Care worker	
Doctor:	Telephone :
Pivotal speaker / CLSC:	Telephone :
Other professional:	Telephone :

User information	
Last Name:	First Name:
Full address:	
Postal Code:	Telephone:
Date of birth:	Age :
RAMQ:	Male □ Female □ Other:
Expiration date of RAMQ :	Single □ Maried □ Widower □ Divorced □
Maternal language: French □ English □ Other □:	

Significant person	
Name:	Relationship: Telephone:
Name:	Relationship: Telephone:

Medical information

Main diagnosis:

Medical background:

Metastases : Brain □ Liver □ Bone □ Lung □ peritoneal □ pleural □ other :

Last treatments received :

Chemotherapy □ _____ Radiotherapy □ _____

Transfusion □ _____ Other □ _____

Allergies :

ESTIMATED PROGNOSIS : - **1 week** □ - **4 weeks** □ - **3 months** □ (- 6 month □ MDC only for respite)

Patient wishes to die in a PCH and is aware of her/his prognosis : YES □

Please complete BACK

Last Name :	**First Name :**

MEDICAL ASSISTANCE IN DYING

Patient wishes to receive Medical Assistance in Dying (MAID) □
Procedures started : Yes □ No □ Admissibility : Yes □ No □
Desired date : _____
Signed waiver form in case of incapacity: Yes □ No □ Why:_____
Name of doctor who completed 1st assessment: _____
Name of doctor who completed 2nd assessment: _____
Nurse present MAID : _____
Venous access: IV#1_____ IV#2_____
PICC line installation request □ (attached to request) Date of installation:_____
All forms attached to the admission application □

Priority issues and needs

Smoker □ _____ cigs/day ; Alcohol □ _____ Drugs □ _____
Automatic Defibrillator □
Functional autonomy: Autonomous □ Partial assistance □ Full assistance □
Oxygen therapy □ _____ L/min
Wounds :_____
Food/particularities: _____
Ostomy □ Urinary catheter □
Last bowel movement: _____
Other:

Psychosocial data

Family situation:

Particular problems:

Please send the following documentation in addition to the application form.

Medical notes □	Nurse's notes □	Pharmaceutical profile /MAS □
Consultations □	Initial request of home support □	Summary/ medical assessment □
Medical imaging □	Relevant diagnostic tests □	Level of medical intervention D signed □
Blood tests □		

Level of medical intervention signed and attached to application □ **Consent to care signed and attached** □

Referring health professional

Name of referent: (Block letters)	**Date:**

Profession:	**Telephone:**	**Ext:**
Signature:	**Establishment:**	

*******Please note that incomplete files will not be evaluated*******