

Voluntary assisted dying

SWSLHD Voluntary Assisted Dying – Central Support Service Referral Form

This referral can only be completed with the patient's consent and if you believe the eligibility criteria under [Section 16](#) of the Voluntary Assisted Dying Act 2022 has been met.

You may consider providing the patient with the [First request patient information guide](#)

For advice and information regarding the completion of this referral please contact the Voluntary Assisted Dying – Central Support Service on **8738 6055** between 8:30am to 4:00pm or email SWSLHD-VAD@health.nsw.gov.au

Information can also be found through the [NSW Voluntary Assisted Dying Clinical Practice Handbook](#)

*Date:	*Time:
MRN:	VAD Portal ID:
PATIENT DETAILS	
*First Name:	*Last Name:
Preferred Name:	*DOB:
*Gender:	*Age:
*Contact:	*Email:
*Address:	
*Family/Carers aware of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Communication Method: <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal
*Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Language:
Aboriginal/Torres Strait Islander Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say	
BEST CONTACT (if different from above)	
*Name:	Relationship:
*Contact:	Email:
REFERRER DETAILS	
*Name:	*Relationship/Role:
*Contact:	*Email:
*Institution/Practice:	*Consent to Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No



Other Relevant Treating Medical Practitioners (GP, Specialist, Geriatrician etc)	
Name:	Relationship/Role:
Contact:	Email:
Institution/Practice:	Consent to Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Relationship/Role:
Contact:	Email:
Institution/Practice:	Consent to Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No
REFERRAL INFORMATION	
*Primary Diagnosis	
*Medical History	
Other Information	
*Reason for Referral	<input type="checkbox"/> Request for Information <input type="checkbox"/> Seeking a VAD Practitioner <input type="checkbox"/> Current VAD Practitioner requesting support and assistance <input type="checkbox"/> Other:
*Print Name:	*Signature:
*Designation:	*Date:
Email the completed form to: SWSLHD-VAD@health.nsw.gov.au Voluntary Assisted Dying – Central Support Service will respond within 1 business day from receiving this form	

Further information can be found on www.health.nsw.gov.au/voluntary-assisted-dying



South Western Sydney
Local Health District

