RAAM CLINIC REFERRAL TEMPLATE[1]

RAPID ACCESS ADDICTION MEDICINE CLINIC REFERRAL FORM

Phone: _____ Fax: _____

Address: _____

CLIENT INFORMATION

Name: _____ Phone: _____

Date of birth: _____ Health Card #: _____

Address: _____

Can a confidential message be left? ☐ Yes ☐ No Referral discussed with client: ☐ Yes ☐ No

Alternative contact #: _____

REFERRAL SOURCE INFORMATION

Individual/agency making referral: _____

Relationship to client/role: _____

OHIP billing # if applicable: _____

Phone: _____ Fax: _____

Primary care provider name if available: _____

Primary care phone: _____ Primary care fax: _____

OAT provider name if applicable: _____

OAT provider phone: _____ OAT provider fax: _____

[1] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

REASON FOR REFERRAL

SUBSTANCES OF CONCERN (check all that apply)

- ☐ alcohol
- ☐ benzodiazepines (e.g., alprazolam/Xanax, diazepam/Valium)
- ☐ cannabis
- ☐ opiates (e.g., fentanyl, hydromorphone/Dilaudid)
- ☐ stimulants (e.g., cocaine/crack, methamphetamines)
- ☐ other: _____

RELEVANT PSYCHIATRIC HISTORY/MENTAL HEALTH HISTORY

RELEVANT MEDICAL HISTORY

MEDICATIONS

ALLERGIES

Signature _____ Date _____