Rapid Access Addiction Medicine Clinic Referral

☐ **Owen Sound** ☐ **Hanover** ☐ **Saugeen First Nation**

Phone Number: 519-376-3999 ext. 2

Please fax completed referrals to: 519-378-1437

Patient Name		**Date of Referral**	
Address		**City**	
Country	Select Country	**Postal Code**	
County	Select County	**Ethnicity**	Select Ethnicity
Gender	Select Gender	**Preferred Pronoun**	
Phone Number		**Date of Birth**	
Official Language		**Preferred Language**	
Health Care Number		**Version Code**	
Referred By		**Family Physician**	
Doctor Billing #			
Does the patient consent to receiving appointment communications via email? ☐ **Yes** ☐ **No**			
Patient Email			

Substance use History (check *all* that apply):

☐ Alcohol	☐ Amphetamines	☐ Cannabis
☐ Cocaine	☐ Hallucinogens	☐ Hypnotics and Sedatives (e.g. benzodiazepines)
☐ Misuse of prescription medications	☐ Nicotine	☐ Opioid
☐ Other:		
Most recently used problematic substance:		Date of Last Use:

Reason for Referral:

☐ Counsellor ☐ Physician ☐ Counsellor and Physician

☐ Other *(case management, food security, peer support)* _____

Relevant Psychiatric/Medical History/Allergies:

List of Current Medications (including treatment initiated e.g. suboxone, methadone):

Other Significant Information (include CIWA/COWS scores, current safety plans, follow up plans, lab work, or requesting transition methadone to suboxone):

Signature:_____ **Date:**_____