



**RAPID ACCESS ADDICTION MEDICINE CLINIC  
REFERRAL FORM**

**525 Simpson Street, Thunder Bay, ON P7C 3J6**

**Phone: (807)-626-8478 Fax: (807)-623-6314**

**PATIENT INFORMATION**

|  |                                  |
|--|----------------------------------|
| Name:  | Phone:                           |
| Date of birth:   | Health Card #:                   |
| Address:   |                                  |
| Can a confidential message be left? Yes <input type="checkbox"/> No <input type="checkbox"/> | Referral discussed with patient: |

**REFERRAL SOURCE INFORMATION**

|                        |                 |
|------------------------|-----------------|
| Name:                  | OHIP Billing #: |
| Phone:                 | Fax:            |
| Primary Care Provider: |                 |

**REASON FOR REFERRAL**

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**SUBSTANCE OF CONCERN**

|               |                         |
|---------------|-------------------------|
| Alcohol       | Nicotine                |
| Amphetamines  | Opiates                 |
| Cannabis      | Sedatives and Hypnotics |
| Cocaine       | Designer Drugs          |
| Hallucinogens | Other                   |

**RELEVANT PSYCHIATRIC HISTORY**

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**RELEVANT MEDICAL HISTORY**

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**CURRENT MEDICATIONS**

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**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_