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 ❑ No ❑	Referral discussed with patient:

REFERRAL SOURCE INFORMATION	
Name:	OHIP Billing #:
Phone:	Fax:
Primary Care Provider:	

REASON FOR REFERRAL

SUBSTANCE OF CONCERN	
Alcohol	Nicotine
Amphetamines	Opiates
Cannabis	Sedatives and Hypnotics
Cocaine	Designer Drugs
Hallucinogens	Other

RELEVANT PSYCHIATRIC HISTORY

RELEVANT MEDICAL HISTORY

CURRENT MEDICATIONS

Signature_____ **Date**_____