HopeRecovery
ADDICTION MEDICINE

Patient Referral Form

PATIENT INFORMATION

Name:	Address:	D.O.B. (DD/MM/YYYY)
Health Card #:	Phone #:	Spoken Language:

SERVICES

	OPIATE REPLACEMENT THERAPY	OTHER SUBSTANCES	OTHER SERVICES
☐ Addiction Services	☐ Methadone ☐ Suboxone ☐ Sublocade	☐ Alcohol Dependancy ☐ Benzodiazepine Dependency ☐ Nicotine Dependency	☐ Drug Screening ☐ Detox Clearance/Referrals ☐ Inpatient Rehab Referral ☐ Addiction Counselling
☐ Psychiatry	☐ Consultation / Psychiatric Evaluation ☐ Medication Optimization (e.g., antidepressants, antipsychotics, mood stabilizers)		
☐ Communicable Disease Screening	☐ Hepatitis C screening and/or treatment ☐ Syphilis screening and/or treatment ☐ Gonorrhoea/Chlamydia screening and/or treatment ☐ HIV screening and/or treatment		

Additional Information : (MEDICAL HISTORY / MEDICATION LIST / SUBSTANCE USE/ HARMFUL BEHAVIOUR)

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REFERRAL SOURCE

Referring MD/NP/Agency/Other:	MD Billing # (If Applicable):
Signature:	Date:

Please forward completed form to Hope Recovery.

Phone: 519-999-4530 Fax: 519-791-9707