RAAM
RAPID ACCESS ADDICTION MEDICINE CLINIC

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PATIENT REFERRAL FORM

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Gender:		Age:	
Address:			
Phone Number:		Ok to leave Message?	☐ Yes ☐ No
Health Card Number:		Version Code:	
Primary Care Provider:			
Is the Patient aware of the referral?	☐ Yes ☐ No *Please be advised all services are voluntary and patient should be aware and accepting of the referral*		
REFERRER INFORMATION			
Referrer Position:	☐ Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other Allied Health		
Name:		Phone Number:	
Organization:		Fax:	
Preferred Follow-Up:	☐ Phone/Voicemail ☐ Fax ☐ No follow up ☐ Other: ____________		
OHIP Billing #:			
REASON FOR REFERRAL			
Why are you referring this person now? *i.e. current symptoms, presenting problems, history etc.*			

MEDICATIONS			
Please attach detailed medication list if available			
SUBOXONE INDUCTION *if applicable*			
Date Started:		Dose on Discharge:	
Prescription Provided Until Date:			
Notes:			

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PATIENT REFERRAL FORM

Prescribing Pharmacy Information:			
COMPLETED BY			
Name:		**Date:**	
Signature:			

Please fax this completed form to **1-855-951-0129**
Contact **1-844-722-2977** with any questions