



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street  
 Toronto, Ontario  
 Healthcare | REVOLUTIONIZED M5S 1B2

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# SUBSTANCE USE SERVICE REFERRAL FORM

REFERRAL DATE: \_\_\_ / \_\_\_ / \_\_\_  
 DD / MM / YYYY

## PATIENT INFORMATION (Affix Patient Label/Identification Here)

MRN: \_\_\_\_\_ HCN: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
 DD / MM / YYYY  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Alternate #: \_\_\_\_\_

### ADDITIONAL PATIENT INFORMATION

Preferred name: \_\_\_\_\_ Gender (if not same as above): \_\_\_\_\_  
 Pronouns:  He/Him  She/Her  They/Them  \_\_\_\_\_  
 Other insurance coverage (IFH, UHIP, etc.): \_\_\_\_\_  Self-pay  
 Language spoken: \_\_\_\_\_ Interpreter required:  Yes  No  
 Telephone number: \_\_\_\_\_  
 Can a confidential message be left?  Yes  No Referral discussed with patient?  Yes  No

### REFERRING PROVIDER INFORMATION

Name: _____	Billing #: _____ Signature: _____
Address: _____	
Telephone: _____	
Fax: _____	

Referring Provider is not the Primary Care Provider  
 Primary Care Provider Name: \_\_\_\_\_  
 Primary Care Provider Telephone: \_\_\_\_\_

### REASON FOR REFERRAL

*Please note we do not need a referral for our Rapid Access Addiction Medicine (RAAM) drop in service.*

### SUBSTANCES OF CONCERN

*Please note we do not accept referrals for nicotine use or behavioural (process) addictions (e.g. gambling, gaming, sex, digital dependence).*

Alcohol  Opioids  Cocaine  
 Amphetamines/Methamphetamines  Benzodiazepines  Other \_\_\_\_\_  
 Cannabis  
 Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Previous treatment trials \_\_\_\_\_

### ADDITIONAL CLINICAL INFORMATION

Mental health history: \_\_\_\_\_  
 Pertinent laboratory results (please attach): \_\_\_\_\_  
 Allergies and reaction: \_\_\_\_\_  
 Current medications (include list): \_\_\_\_\_

### PERMISSION TO CONTACT

By providing the patient's email address, you are confirming that the patient has consented to receiving email communications from WCH regarding their appointment(s), patient experience surveys, enrollment in our patient portal (myHealthRecord), and other medical documentation.  
 Patient email address: \_\_\_\_\_  
 Disclaimer: All electronic communication carries some risk. Patients may withdraw their consent to receive emails from WCH or change their preferences at any time.

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.

