BRANTFORDRAAM
RAPID ACCESS TO ADDICTIONS MEDICINE CLINIC

Date of Referral: _____

Referred by: _____ **E-mail:** _____

Patient Demographics:

Name: _____

Health Card #: _____

Date of Birth (day/month/year): _____

Gender: _____ Phone #: _____

Address (including postal code): _____

_____

Patient Substance Use Information (check all that apply)

☐ Alcohol Use ☐ Cannabis Use ☐ Benzodiazepine Use ☐ Opioid Use
☐ Stimulant Use ☐ Hallucinogen Use ☐ Concurrent Disorder

☐ Other: _____

_____

Patient's Goal: _____

_____

Medical Information

Pharmacy: _____

*Attach medication list

Medical Conditions: _____

_____

Allergies: _____

Other relevant information: _____

_____

PARTNER AGENCIES

GRAND RIVER COMMUNITY HEALTH CENTRE
SOAR COMMUNITY SERVICES
DE DWA DA DEHS NYE>S ABORIGINAL HEALTH CENTRE
CANADIAN MENTAL HEALTH ASSOCIATION BRANT HALDIMAND NORFOLK

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