BRANTFORDRAAM
RAPID ACCESS TO ADDICTIONS MEDICINE CLINIC

Patient Demographics (complete or adhere label) **Date of Referral:** _____

Name: _____

Health Card #: _____

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

Gender: _____ Phone #: _____

Address (including postal code): _____

_____

Patient Substance Use Information (check all that apply)

☐ Concurrent Disorders ☐ Alcohol Use ☐ Cannabis Use

☐ Benzodiazepine Use ☐ Opioid Use ☐ Stimulant Use

☐ Hallucinogen Use ☐ Drug induced psychosis ☐ Pregnant

☐ Withdrawal follow up (Substance(s): _____

☐ Other: _____

_____

Treatment Initiated

☐ Suboxone _____mg ☐ Methadone _____mg ☐ Kadian _____mg

☐ Naltrexone _____mg ☐ Campral _____mg ☐ Gabapentin _____mg

☐ Olanzapine _____mg ☐ Lorazepam _____mg ☐ Diazepam _____mg

☐ Other _____

☐ **Prescription Provided** **# of Days** _____ **Pharmacy:** _____

Medical Practitioner Name: _____

Signature: _____

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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