Addiction Services
of Thames Valley | Services de toxicomanie de Thames Valley

Community Opioid Addiction Program
REFERRAL FORM

ADDRESSOGRAPH

☐ **VERBAL CONSENT HAS BEEN OBTAINED** (please obtain before submitting referral)

Internal ADSTV Referral (Open File)
☐ Yes ☐ No (*if Yes, please only complete areas with **)

***CLIENT'S NAME**:_____ ***D.O.B. (d/m/y)**: _____
GENDER: ☐ Female ☐ Male ☐ Other
TELEPHONE: ( ) n/a_____ Okay to leave message? ☐ Yes ☐ No
Located in Thames Valley Region:
☐ London ☐ Middlesex County ☐ Elgin County ☐ Oxford County

***ELIGIBILITY CRITERIA (check all that apply):**
☐ Historical use of opioids
☐ Accessing substitution therapies (e.g. methadone, suboxone, subutex)
☐ Current use of opioids
☐ Seeking information on opioid use and/or opioid substitution therapy

***PRIORITY POPULATION (check all that apply):**
☐ Women who are pregnant or parenting
☐ People who have blood-borne illnesses (e.g. HIV/AIDS or Hepatitis C)
☐ Youth (London/Middlesex-21 and under, Elgin-18 and under, or Oxford-18 and under)

REFERRING AGENCY: _____
*****Contact Name: _____ Phone**:** (519) _____ext ____
Fax**:** ( )_____ Email**:**_____
ADDITIONAL COMMENTS:_____
_____

Signature:_____ **Date**:_____

FOR OFFICE USE ONLY

Date Received:		**Received By:**
Existing Client? Y / N	**Catalyst #:**	**File Status:**
Next Steps: _____		

FAX COMPLETED FORM TO: 519-673-1022

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Name: _____
Catalyst #: _____

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

All Addiction Services of Thames Valley (ADSTV) employees are mandated under law to protect the personal health information and clinical records of every client. Signing this form will allow consent for the sharing/disclosure of your personal health information between ADSTV and the agency/ person noted below.

I _____, born on _____
(Print name) (dd/mm/yyyy)

authorize Addiction Services of Thames Valley (ADSTV) to:

☐ (initial) disclose and/or

☐ (initial) receive

my personal health information with

_____, as follows:
Print the name of the agency/ person with whom you permit ADSTV to share your personal health information

Relevant information from my clinical file _____
Initial

Or specifically:

_____ _____
Initial

_____ _____
Initial

_____ _____
Initial

_____ _____
Initial

This consent shall be in effect until _____.
dd/mm/yyyy

This agreement may be cancelled by you at any time.

_____ _____
Signature Date

_____ _____
Witness Name (Please Print) Witness Signature

Pursuant to the Personal Health Information Protection Act (PHIPA), 2004