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

Community Withdrawal Support Program
Referral Form

The following referral form is intended for an agency / organization who wish to refer a client to the Addiction Services of Thames Valley's Community Withdrawal Support Program. Once completed, **please fax to (519) 673-1022**

New Referral ☐ Yes ☐ No

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

*** Name:** _____ ***Date of birth** (d/m/y):_____

Last name at birth: _____ **Primary phone:** ( ) _____
Okay to call ☐ Yes ☐ No
Leave message ☐ Yes ☐ No

Other phone: ( ) _____
Client's gender _____ Okay to call ☐ Yes ☐ No
Leave message ☐ Yes ☐ No

Does the client have a fixed address? *** Call restrictions**: _____
☐ Yes ☐ No
Street address: _____ **Apt/Unit**: _____

City: _____ **Postal Code**: _____

*** Presenting Need (*Check all that apply*):**

☐ Community Withdrawal Management
☐ STOP Smoking Cessation
☐ Rapid Access Addiction Medicine

*** For Community Withdrawal Management and Rapid Access Addiction Medicine:**
Problematic Substance/s: _____

Requests: Withdrawal Planning ☐ Active Withdrawal Support ☐ Relapse Prevention ☐

*** Medical Conditions/ History:**

_____

_____

Current Family Doctor/Nurse Practitioner ☐ Yes Name: _____ ☐ No

*** Psychiatric Diagnosis:**

_____

If yes, current Psychiatrist ☐ Yes Name: _____ ☐ No

Referring Agency:

_____

*** Contact name**: _____ **Phone**: ( ) _____Ext:____

Fax: ( ) _____ **Email**: _____

Ontario Telemedicine Network equipment available at referring site? ☐ Yes ☐ No

If yes, Site #_____ System #_____

I would like to receive feedback about the client's involvement with the Community Withdrawal Support Program at ADSTV ☐ Yes ☐ No
(To receive feedback, the client must sign the *Consent for Release of Information* and/ or *Consent to the Collection, Use and Disclosure of Personal Health Information*)

Contact: Please *choose one of the following:*

☐ Please contact me (referring agency) **BEFORE** contacting client.

☐ Upon receiving referral, please contact client directly.

CWSP may contact referring agency for additional information as required.

Additional comments:

_____
_____
_____
_____

Signature: _____**Date**: _____

FOR OFFICE USE ONLY

DATE RECEIVED:	CONTACTED ☐ Yes ☐ No	INITIALS:
INTAKE COMPLETED ☐ Yes ☐ No	INTAKE DATE ☐ Yes ☐ No	INITIALS:
ELIGIBLE ☐ Yes ☐ No	APPOINTMENT BOOKED ☐ Yes ☐ No	INITIALS: