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:

_____

__

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

519 758 8443 - PHONE
226 250 1037 - FAX
12 MARKET ST.
BRANTFORD, ON.

_____
_____

Medical Information

Pharmacy:
_____
_____

*Attach medication list

Medical Conditions:
_____

_____
_____

Allergies:
_____
_____

Other relevant information:

_____

_____
_____