# Brantford Brant Safer Opioid Supply Referral Form

*Participants can self-refer, or may be referred to the BBSOS program by a service provider who has a client that has interest in safer supply.*

*Referrals can be submitted via email, fax or in person at 363 Colborne St, Brantford. In person referrals may be accepted during drop-in hours based on capacity. Please note that we are only able to accommodate 40 people in the BBSOS program currently.*

**Referral Date:** _____

## Client Information

| Last Name | First Name | Date of Birth | Sex (same as health card) |
|---|---|---|---|
| | | | |

| Gender | Pronouns | Preferred Language | Health Card Number |
|---|---|---|---|
| | | | |

| Address/Where are you staying? | Phone Number |
|---|---|
| | |

| Email | Drug Coverage (OHIP+, ODB, OW, ODSP, NIHB, other) |
|---|---|
| | |

## Referring Organization/Provider (if relevant)

| Name | Organization | Phone/Fax |
|---|---|---|
| | | |

*September 2022*

## Substance Use History

**Do you use opioids?**

**Substance of choice: _____**

Yes No

**How many points/ how much per day? _____**

**How do you use? (Please check all that apply)**

| | |
|---|---|
| **Injection** | **Muscling** |
| **Smoking** | **Other:** |
| **Snorting** | |

**What other substances do you use? (Please check all that apply)**

| | |
|---|---|
| **Crystal Methamphetamines** | **Hydromorphone (unprescribed)** |
| **Crack** | **Benzodiazepines (unprescribed)** |
| **Cocaine** | **Alcohol** |
| **Marijuana** | **Other:** |

**How many times have you overdosed in the last month? _____**

**Are you currently taking: (circle all that apply)**

Methadone Suboxone Slow-Release Oral Morphine

**Have you previously taken: (circle all that apply)**

Methadone Suboxone Slow-Release Oral Morphine

## Activities related to substance use

**Do you participate in high-risk activities related to substance use? (ex. sex work)**

Yes No

## Housing

**Do you have stable housing?**

Yes No

**Where do you normally shelter?**

_____

## Medical Information

**Do you have a primary care provider?**
Yes No

**Are you interested in primary care at GRCHC?**
Yes No

**If you have a provider, please include their name and phone #: _____**

**Have you previously or recently experienced any of the following health concerns?**

| | | |
|---|---|---|
| **Bowel Obstruction or paralytic ileus** | **Endocarditis** | **Sepsis** |
| **Lung, Kidney or Liver disease** | **HIV** | **Hepatitis C** |
| **Seizures that are unmanaged** | **Allergic reaction to Hydromorphone** | |

**How many times have you been to the emergency department in the last six months? _____**

**Anything else we should know about you? _____**

***Please submit the completed referral via:***
****Email: bbsos@grchc.ca*
*Fax: 519-754-0757* ***ATTN: Safer Opioid Supply***
*In person: Grand River Community Health Centre (363 Colborne St., Brantford)*

**Please note that we will be in contact with you to discuss our services and options for the safer supply program once we receive and have reviewed the information on your referral form.**.

*All information collected on the referral form is confidential and is protected under the Personal Health Information Protection Act. The communication provided is solely for the use of the BBSOS program and will not be shared without consent.*

****Please note that communications via email over the internet are not secure. Although unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. By sending the referral form or any other information over email to BBSOS@grchc.ca, you are accepting this risk.*

*September 2022*