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Extraordinary Caring. Every Person. Every Time.

Adult Outpatient Referral Form
Mental Health and Addictions

Rapid Access Addictions Management (RAAM) Clinic x49463 Fax 289-1067

SECTION A: Client Information **Is client aware of referral?** ☐ **Yes** ☐ **No**

Client Name: _____ HC with Version Code: _____
Address: _____ City/Town: _____
Telephone: (H) _____ leave message ☐ Y ☐ N (C) _____ leave message ☐ Y ☐ N
Date of Birth: _____ (dd/mm/yyyy) Birth Gender: ☐ Male ☐ Female Identified Gender: _____
Name of Family Physician: _____ Phone Number: _____
Psychiatrist: _____ Phone Number: _____

SECTION B: (if referring to multiple programs, please number priority of services)

Program Requested:	Reason for Referral:	Internal Use Only:
☐ CAPS – Centralized Access to Psychiatric Services #____ **(physician/NP referral only)**	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ Urgent Access Nurse Practitioner **(NH ED Physician Only)** #____	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ RAAM – Rapid Access to Addiction Medicine #____	☐ Alcohol ☐ Opiates ☐ Other:	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ Seniors Mental Health #____ **(physician/NP referral only)**	☐ Cognitive Decline ☐ New Mental Health ☐ Longstanding Mental Health	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
Contact Person for Appointment: _____ Relationship: _____ Phone Number: _____ INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS		
☐ WRICCP – Wellness Recovery Integrated Comprehensive Care Program #____	**Must meet ALL the following criteria:** ☐ Recent suicide attempt ☐ Recent / frequent ED / Admission Inpatient ☐ Acute phase of mental health illness ☐ Significant impact to functioning	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ Adult Group Therapy (check one) ☐ Depression ☐ Anxiety #____ ☐ Schizophrenia ☐ ADHD	☐ Bipolar ☐ Emotion Dysregulation ☐ Pain Control and Wellness	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ Day Hospital (3 days per week SCS only) #____	☐ Complex mental health ☐ Impairments with daily functioning	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ GEM – Guiding Emotions Mindfully (1.5 days per week SCS only) #____	☐ Severe emotion dysregulation ☐ History of trauma	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ Medication Clinic – to complete this referral **you must also go to page 3** to input additional required information #____		Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A

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SECTION B: (Continued)

Program Requested:	Reason for Referral:	Internal Use Only:
☐ ECT – Electroconvulsive Therapy – to complete this referral, you must also go to Page 4 to input additional required information #____		Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ rTMS – Repetitive Transcranial Magnetic Stimulation – to complete this referral, you must also go to Page 5 to input additional required information #____		Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A
☐ CTO – Community Treatment Order #____	Assess Suitability ☐ 30+ days inpatient mental health admission within past 3 years ☐ 2 lengthy inpatient mental health admissions within past 3 years ☐ Previous CTO in the past	Appt. Date: _____ Completed: _____ See Notes: ☐ Yes ☐ N/A

SECTION C: PRESENTING SYMPTOMS:

Current challenges / concerns: _____

Previous / Current Mental Health Diagnosis (**must indicate mild / moderate / severe** as per PHQ–9): ☐ attached PHQ–9

Previous / Current Medical Diagnosis: _____

Previous / Current Medication(s) / Dosages: ☐ attached medication list

Allergies: _____

SECTION D: RISK **Please complete the following chart:**

Problem	Present (within past 6 months)		Past (6 months or more)		Denied	Unknown
	Yes	No	Yes	No		
Alcohol / Substance Use						
Violent Behaviour						
Suicidal Ideation						
Suicidal Attempts						
Self–Harming Behaviour						

If answered yes above, please identify / report concerns: _____

Referring Source (print): _____ MD/NP Billing #: _____

Referring Source Phone: _____ Referring Source Fax: _____

Signature: _____ Referral Date: _____ (dd/mm/yyyy)

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NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

Rapid Access Addictions Medicine (RAAM) Clinic
PATEINT INFORMATION SHEET

Affix Patient Label

What Will Happen Next?

You have been referred to The RAAM (Rapid Access Addictions Medicine) Clinic. It is for people looking for help with their substance use (alcohol and/or other drugs). The clinic will contact you in the next couple of days for your appointment. If you do not hear from them within 2 business days, please contact them at 905 378 4647 x49463.

The doctors at RAAM clinic have experience treating people who are struggling with substance use and know how difficult it is to ask for help. You can always self refer to the clinic.

How To Get to the Clinic?

The Clinic is situated at the main floor of the St. Catharines Site on 1200 Fourth Avenue. Go to the Mental Health Program Entrance Patient Registration window to register on the day of your appointment. This is located at the South-East corner of the building and has parking close by.

If you are feeling nervous or hesitant about going to the clinic, feel free to bring along a supportive friend or family member. You are welcome to come to the clinic even if you are not sure that you have a substance use problem or if you know you have a problem but you are not ready to stop yet.

Why Addictions Medicine?

A substance use disorder is a medical diagnosis for problematic drug/alcohol use (using more than intended, spending a lot of time getting and using substances) that results in negative life consequences (problems at home, work or health, spending less time on things you enjoy, etc.). Depending on how you use these substances and the consequences, the doctor may diagnose you with this disorder. Substance use disorders are treatable conditions and with help, people can and do recover.

There are multiple effective medications that may be offered for treatment of substance use, withdrawal, and craving. These medications may relieve these symptoms and then allow you to focus on establishing a healthy lifestyle. The RAAM clinic doctor may refer you to counseling as part of your treatment. Treatment and/or referrals may also be offered as necessary for any co-occurring mental illness that you may have.

Family Doctors

Your family doctor is central in your overall healthcare. If you do not have a family doctor, we strongly advise you to get one. You can find help at www.niagaradocs.ca or by calling **Healthcare Connect Ontario at 1-800-445- 1822.** The city of St Catharines provides similar information on their website www.stcatharines.ca or by calling 905.359.6043.

Thank you

PLEASE GIVE TO THE PATIENT BEFORE DISCHARGE FROM ED

Niagara Health System
Système De Santé De Niagara

St. Catharines Site
1200 Fourth Avenue, St. Catharines, ON, L2S 0A9
Telephone 905-378-4647
www.niagarahealth.on.ca

Name_____

Address_____

Rx

Date _____

Suboxone (Buprenorphine/Naloxon)

Sub Lingual Tab

Daily Witnessed Administration

Dose (as checked):

[ ] 2mg/0.5mg

[ ] 4mg/1mg

[ ] 8mg/2mg

[ ] _____

For 7 days only Start Date _____

LU Code 438 End Date _____

PS2500

DR._____

DO NOT REPEAT

PHARMACIST_____