

ADDICTION CENTRE ADULT PROGRAM PATIENT REFERRAL INFORMATION

The mandate of the Addiction Centre Adult Services is the assessment and treatment of adults with substance related issues and/or behavioural addictions combined with either a major psychiatric or physical disorder (e.g. chronic pain)

Patient Name: _____ Date: _____
(Please Print Clearly)

Date of Birth: (YY/M/D) _____ PHN/AHC#: _____ - _____

Telephone Numbers: _____ / _____ / _____
(Home) (Work) (Cell)

Address: _____
(Street)

(City) (Province) (Postal Code)

Physician of Record: _____ Office Number: _____

Psychiatrist/Psychologist/Specialty Clinic of Record: _____

***NOTE: All patients referred to the Addiction Centre must have written referral/approval from the family physician in order for an assessment to be arranged.**

Emergency Contact: _____ Phone Number: _____
(Reliable) (Reliable)

ASSESSMENT REQUIREMENTS:

Ability to sit through 2 1/2 hour assessment (stretching/breaks permitted): Yes No

Ability to read/write: Yes No

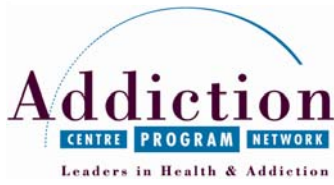
Requires Translator: Yes No

MENTAL HEALTH CONDITION:

Presenting Problems/Working Diagnoses:

Previous Mental Health History:

Please fax (944-2056) or send original by mail to:
Addiction Centre, Foothills Medical Centre, 1403-29 Street NW Calgary AB T2N 2T9
We will contact the patient directly for an appointment. If you have any questions with regards to this referral, call 944-2025 and ask to talk to the intake worker.



HOSPITALIZATION:

Is client currently hospitalized: Yes No If yes, where: _____

ADDICTION PROFILE:

Current Substance(s) of Choice	Duration of Use
_____	_____
_____	_____
_____	_____

Current Amount and Frequency:

Gambling/Other Addictive Behaviors:

Previous treatment support services attended:

- Renfrew Recovery Centre Alpha House 1835 House Addiction Centre
- AADAC Outpt. Services Aventa David Lander's Henwood
- Oxford House Simon House South Country Youville
- Self Help Groups Addiction Network Other: _____

LEGAL HISTORY:

Violence Potential or History: Yes No

Current Legal involvement: Yes No

History possession/trafficking of narcotics: Yes No

Please provide further details as required:

ADDITIONAL COMMENTS:

Signed: _____ **Date:** _____

(Please include any relevant patient documents)

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