Insert primary care clinic logo/contact info

Opioid Stewardship Referral Form

Services provided by *(insert clinic name)*

|  |  |  |
| --- | --- | --- |
| **Instructions** | **Next Steps** | |
| 1. Fill out as many fields below as possible 2. Attach relevant documents (e.g., consult notes) 3. Submit by: 4. Fax: *(insert Fax number)* 5. Secure e-mail: *(insert URL)* 6. Inform the patient that a referral was submitted | 1. Patient will be contacted directly to book their appointment 2. Patient will receive follow-up information by e-mail 3. Referring person will receive a notice of appointment once booked | |
| **Urgency of Referral** | **Name of Referring Provider** | |
| * **Urgent:** see within 1-2 business days of discharge * **Non-Urgent:** see within 1-2 weeks of discharge * **Routine:** see within 1-2 months of discharge   **Discharge Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| **Phone** | **Fax** |
|  |  |

**Patient Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Legal Name\* | | Name Used | | | |
|  | |  | | | |
| Personal Health Number | Date of Birth (D/M/Y) | | | Gender\* | Pronouns |
|  |  | | |  |  |
| Address (number, street, city, province, postal code) | | | | | |
|  | | | | | |
| Phone | | | Email Address | | |
|  | | |  | | |
| Community Pharmacy (name, location, phone) | | | | | |
|  | | | | | |

\* Legal name and gender as stated on your BC Services Card is collected to access health records. We recognize that a person's name and gender can differ from what is on their government issued ID.

**Reason(s) for Referral**

|  |
| --- |
|  |

**Send a Copy of Consultation Report to…**

|  |  |  |
| --- | --- | --- |
| Name | Phone | Fax |
|  |  |  |

last update: 2024\_04\_29