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