

**Community Opioid Addiction Program
REFERRAL FORM**

ADDRESSOGRAPH

VERBAL CONSENT HAS BEEN OBTAINED (please obtain before submitting referral)

Internal ADSTV Referral (Open File)

Yes No (if Yes, please only complete areas with *)

***CLIENT'S NAME:** _____ ***D.O.B. (d/m/y):** _____

GENDER: Female Male Other

TELEPHONE: () n/a _____ Okay to leave message? Yes No

Located in Thames Valley Region:

London Middlesex County Elgin County Oxford County

***ELIGIBILITY CRITERIA (check all that apply):**

- | | |
|---|---|
| <input type="checkbox"/> Historical use of opioids | <input type="checkbox"/> Current use of opioids |
| <input type="checkbox"/> Accessing substitution therapies (e.g. methadone, suboxone, subutex) | <input type="checkbox"/> Seeking information on opioid use and/or opioid substitution therapy |

***PRIORITY POPULATION (check all that apply):**

- Women who are pregnant or parenting
- People who have blood-borne illnesses (e.g. HIV/AIDS or Hepatitis C)
- Youth (London/Middlesex-21 and under, Elgin-18 and under, or Oxford-18 and under)

REFERRING AGENCY: _____

*Contact Name: _____ Phone: (519) _____ ext _____

Fax: () _____ Email: _____

ADDITIONAL

COMMENTS: _____

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Date Received:		Received By:	
Existing Client? Y / N	Catalyst #:	File Status:	
Next Steps: _____			

Name: _____
Catalyst #: _____

**CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

All Addiction Services of Thames Valley (ADSTV) employees are mandated under law to protect the personal health information and clinical records of every client. Signing this form will allow consent for the sharing/disclosure of your personal health information between ADSTV and the agency/ person noted below.

I _____, born on _____
(Print name) (dd/mm/yyyy)

authorize Addiction Services of Thames Valley (ADSTV) to:

(initial) disclose and/or

(initial) receive

my personal health information with

_____, as follows:
Print the name of the agency/ person with whom you permit ADSTV to share your personal health information

Relevant information from my clinical file _____
Initial

Or specifically:

_____	_____
	Initial
_____	_____
	Initial
_____	_____
	Initial
_____	_____
	Initial

This consent shall be in effect until _____.
dd/mm/yyyy

This agreement may be cancelled by you at any time.

Signature

Date

Witness Name (Please Print)

Witness Signature