Addiction Services
of Thames Valley | Services de toxicomanie de Thames Valley

TeleWithdrawal & Crisis Support Program
REFERRAL FORM

The following referral form is intended for an agency / organization who wishes to refer a client to the Addiction Services of Thames Valley's TeleWithdrawal & Crisis Support Program. Once completed, **please fax to (519) 673-1022.**

Internal ADSTV Referral (Open File)? ☐ Yes ☐ No *if* Yes, *please only complete areas with* *

*** NAME:** ______________________________ ***D.O.B.** (d/m/y): ____________________________

LAST NAME at BIRTH: ________________

HOME PHONE: ( ) ______________________
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

GENDER: ☐ Male ☐ Female ☐ Other

OTHER PHONE: ( ) ______________________
Okay to call? ☐ Yes ☐ No
Leave message? ☐ Yes ☐ No

DOES THE CLIENT HAVE A FIXED ADDRESS? ☐ Yes ☐ No

*** CALL RESTRICTIONS**: _____________________

STREET ADDRESS: _____________________________________ **APT/UNIT**: __________________

CITY: _________________________________ **POSTAL CODE**: _____________________

*** PRESENTING PROBLEM/CONCERN (Check all that apply):**
☐ Community Withdrawal Management ☐ Crisis Support ☐STOP (for internal referrals only)

*** For Community Withdrawal Management:**
Substance of Choice: ____

Service: Withdrawal Planning ☐ Active Withdrawal Support ☐ Relapse Prevention ☐

*** For Crisis Support:**
Presenting concern: ____

*** Medical Conditions/ History:**
____

(Do they currently have a GP/Family Doctor? ☐ Yes ☐ No)

*** Psychiatric Diagnosis:**
____

(If Yes, do they currently have a Psychiatrist? ☐ Yes ☐ No)

REFERRING AGENCY:
____

*** CONTACT**: ____________________________ **PHONE**: (   ) _______________ **EXT**: ___________

FAX: (   )_____________________ **EMAIL**: ____

OTN EQUIPMENT AVAILABLE AT REFERRING SITE? ☐ Yes ☐ No

(IF Yes, Site#____________________ System #__________

I WOULD LIKE TO RECEIVE FEEDBACK REGARDING CLIENT'S INVOLVEMENT WITH ADSTV
(To receive feedback, the client must sign the *Consent for Release of Information* and/ or *Consent to the Collection, Use and Disclosure of Personal Health Information*) ☐ Yes ☐ No

CONTACT *Please choose one of the following:*

☐ Please contact me (referring agency) **BEFORE** contacting client.

☐ Upon receiving referral, please contact client directly.

** TWCSP may contact referring agency for additional information as required.*

ADDITIONAL COMMENTS:
____
____
____
____

SIGNATURE: ____ **DATE**: _________________________

FOR OFFICE USE ONLY

DATE RECEIVED:	CONTACTED? ☐ Yes ☐ No	INITIALS:
INTAKE COMPLETED? ☐ Yes ☐ No	INTAKE DATE? ☐ Yes ☐ No	INITIALS:
ELIGIBLE? ☐ Yes ☐ No	APPOINTMENT BOOKED? ☐ Yes ☐ No	INITIALS: