



Rapid Access Addiction Medicine (RAAM) Clinic Referral Form

This referral form is intended for an agency/organization that wishes to refer a client to the Canadian Mental Health Association of Thames Valley Addiction and Mental Health Services RAAM Clinic. Once completed, please fax to **(519) 673-1022**. For internal referrals, please add the referral to catalyst and email the RAAM team indicating a referral is on file.

Client Information:

Name: _____	Referral Date: _____
Date of Birth (dd/mm/yy): _____	Gender: _____
Street Address: _____	
Health Card Number: _____	VC: _____ Exp.Date: _____
City: _____	Postal Code: _____
Primary Phone: _____	Okay to call <input type="checkbox"/> Yes <input type="checkbox"/> No
	Leave message <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone restrictions: _____	Allergies: _____

Referral Information:

Referral Source: _____	Referral Name: _____
Phone: _____	Fax: _____
Reason for Referral: 	
Treatment Initiated (if any): 	
Billing #: 	
Please attach relevant medical/psychiatric history and current medication list	
For Internal CMHA Referrals Only:	File Open: <input type="checkbox"/> Yes <input type="checkbox"/> No
Catalyst #: _____	Referral on File: <input type="checkbox"/> Yes <input type="checkbox"/> No

****Please inform client that a urine sample is required at each clinic visit****

Clinic Hours:
Mondays 8:30-11:30am and 12:30-3:30pm
Tuesdays 8:30-11:30am
Wednesday 7:30-10:30am
Thursday 8:30am-3:30pm
(Closed on all Statutory Holidays)