CHUM Referral Form - Addiction Medicine Service

For Indigenous Patients Only

Assessment completed by *(name/title if applicable*):

Name and contact information of the organization/health centre:

Staff contact information *(if applicable)*:

Community *(if applicable)*:

Patient identification/ Registration information:

Last name, First name:

Date of birth:

Gender (as written on health care card): Gender identity:

Father's name: Mother's name:

Address:

Telephone number:

Email address:

Band # (*if applicable*):

RAMQ (#/expiry date):

Community pharmacy:

Family physician:

Emergency contact:

Reason of referral:

Drug of choice: Opioids ☐ Other substance(s) ☐ Specify:

Other comments: patient preoccupations, HVC and IV testing, vaccination, other health issues that need to be communicated to CHUM team:

Please return by fax at: 514-412-7401 **or** **by email**: smt.autochtone.chum@ssss.gouv.qc.ca