

## Rapid Access Addiction Medicine (RAAM) Clinic

The RAAM Clinic is a SJHH service offering urgent, medication assisted treatment for alcohol and opioid use disorders. Patients will be transitioned to an addictions clinic, primary care physician, or other care setting.

Referred By: \_\_\_\_\_ Service/Program: \_\_\_\_\_

Referral source contact info: Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physicians billing # (if applicable): \_\_\_\_\_ Date of Referral: \_\_\_\_\_

### PATIENT INFORMATION:

Name: \_\_\_\_\_ Health Card Number: \_\_\_\_\_

SJHH/HHS MRN (if applicable): \_\_\_\_\_ Preferred Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F / Other: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Substance Use Disorder (identify substances): \_\_\_\_\_

Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> taking more or for longer than intended  | <input type="checkbox"/> unsuccessful efforts to stop or cut down use     |
| <input type="checkbox"/> craving for substance  | <input type="checkbox"/> recurrent use in hazardous situations            |
| <input type="checkbox"/> failure to fulfill major obligations due to use  | <input type="checkbox"/> withdrawal symptoms when not using or using less |
| <input type="checkbox"/> important activities given up or reduced because of substance use                              |   |
| <input type="checkbox"/> tolerance to effects of the substance  |   |
| <input type="checkbox"/> spending a great deal of time obtaining, using, or recovering from use                         |   |
| <input type="checkbox"/> continued use despite problems caused or exacerbated by use                                    |   |
| <input type="checkbox"/> continued use despite physical or psychological problems that are caused or exacerbated by use |   |

Patient consents to referral: YES  NO

Patient interested in treatment for substance use disorder? : YES  NO

Has any treatment been initiated? YES  NO  If yes, please specify: \_\_\_\_\_

Current Medications: (Please print clearly or attach medication list):

Allergies: \_\_\_\_\_

Additional clinical comments:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (DD/MM/YYYY)

To refer: **Phone** (905) 522-1155 x35800 (leave message), **Text** (905) 870-2760,  
or **fax** this form to (905) 521-9098

**(Please note this is NOT a pain clinic and opioid prescriptions for pain will not be provided)**