GARUDA CENTRE

GET GROUNDED.

# REFERRAL FORM

## HOW TO SUBMIT REFERRAL

**PLEASE SIGN + FAX COMPLETED FORM TO: 250 754 5245**

To help us provide the best care possible, please complete the Informed Consent section with the patient and include relevant documents, such as: patient medical summary sheet, previous addiction and/or psychiatric consultations, discharge summaries, medication lists, psychological reports, lab + test results (e.g., recent UDS).

## GENERAL ADMISSION CRITERIA

- ✔ **Relevant ICD9 diagnosis**
  *Physician or Nurse Practitioner referral*
- ✔ **19+ y/o with min 1-month alcohol + substance free**
  *Includes all cannabis/marijuana/mind-altering drugs*
- ✔ **Alcohol + substance free living space**
  *For the duration of the 90day program*
- ✔ **Medically cleared for rigorous activity**
  *90min yoga/exercise + 90min intensive group session*
- ✔ **Community healthcare provider/clinic**
  *For medical needs/concerns during the program*
- ✔ **If on OAT has outside provider†**
  *Can be on stable dose or slow taper (≥3m)*
- ✔ **No history of violent behaviours**
  *Does not have criminal/legal issues pending*
- ✔ **No active psychosis/suicidality/ptsd for past 6m**
  *Does not have disorder that interferes with group learning*
- ✔ **Has completed medical detox/rehab program**
  *Or equivalent w/documentation + no active withdrawal*
- ✔ **In Preparation ⇋ Maintenance stages of change**
  *Understands this is a 90-day commitment 10h/wk*

## INFORMATION FOR REFERRING PROVIDERS

A physician or nurse practitioner referral is required for the Behavioural Medicine Aftercare Programs (BMAP) as they are billed in part through MSP as 'group medical visits' requiring a specific ICD9 diagnosis.

It is preferred that the referral come from the treating healthcare professional.

Please ensure your patient is aware that the referral is being made.

Garuda Centre will make two attempts to contact the patient and leave two voicemails (when consent is provided). If the patient cannot be reached, the referring provider will be notified.

Please encourage your patient to call Garuda Centre to check on the status of their referral if they have not heard back within 10 business days of its submission.

**APPROPRIATE REFERRALS** are greatly appreciated and allow us to offer grassroots outpatient programs with limited resources. Completed referral forms are not a guarantee of admission as programs run out of a small community style facility, which is restricted to 10 participants per program.

**A HIGHER LEVEL OF CARE** may be recommended based on: patient comorbidities, ability to participate in program activities safely, and severity of illness. Garuda Centre is a teaching centre, therefore your patient may have residents or students involved in their care.

### LEARN MORE ABOUT OUR PROGRAMS

*Access downloadable forms at garudacentre.com.*
*For any questions about the referral process or programs, please call 250 754 3686 or email: info@garudacentre.com*

† *If your patient is already on a stable dose of OAT but does not have a community provider for the duration of the program we can recommend local options prior to admission. We support, but do not provide OAT inductions, maintenance or tapers at Garuda Centre.*

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Clear Referral

PATIENT ID LABEL

(GARUDA CENTRE USE ONLY)

# REFERRAL FORM



**PLEASE COMPLETE ALL BOXES LEGIBLY. FORMS SUBMITTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED. A FILLABLE-PDF VERSION OF THIS FORM IS AVAILABLE AT GARUDACENTRE.COM/RESOURCES-DOWNLOADS FORMS FILLED ONLINE MUST BE PRINTED, SIGNED AND FAXED TO GARUDA CENTRE AT 250 754 5245**

## REFERRER INFORMATION

| | | | |
|---|---|---|---|
| REFERRER NAME | | CLINIC | |
| REFERRAL DATE *DD/MM/YYYY* | PHONE | ** FAX ** | BILLING NUMBER |

REFERRING HEALTHCARE PROFESSIONAL: ☐ PHYSICIAN ☐ NURSE PRACTITIONER ☐ OTHER:

EMAIL

SELECT SERVICE: ☐ REHAB AFTERCARE FOR MEN *(RAM)* ☐ REHAB AFTERCARE FOR WOMEN *(RAW)*

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| PATIENT NAME | | DATE OF BIRTH *DD/MM/YYYY* | PHN |
| AGE | GENDER | PHONE | ** EMAIL ** |

CONSENT TO VOICE-MAIL MESSAGES: ☐ YES ☐ NO

CONSENT TO E-MAIL COMMUNICATION: ☐ YES ☐ NO

MAILING ADDRESS

| | |
|---|---|
| EMERGENCY CONTACT + RELATIONSHIP | PHONE |

FAMILY PHYSICIAN ☐ *SAME AS REFERRING HEALTH PROFESSIONAL*

| | | |
|---|---|---|
| PHONE | ** FAX ** | CLINIC |

REASON FOR REFERRAL - CURRENT PROBLEMS AND Hx + SUBSTANCE USE, AMOUNT, FREQUENCY ☐ *OR, Hx ATTACHED*

DIAGNOSIS AND ICD9 CODE

CONDITIONS - PLEASE MARK ALL THAT APPLY, AND ADD FURTHER DETAILS FOR CONDITIONS WITH A '*' UNDER PMHx

☐ ANXIETY ☐ CHRONIC PAIN ☐ DEPRESSION ☐ PTSD (NO ACTIVE SYMPTOMS) ☐ INSOMNIA ☐ ACUTE STRESS SITUATION
☐ EATING DISORDER* ☐ OTHER SUD + BEHAVIOURAL ADDICTIONS* ☐ Hx OF SEIZURES* ☐ PERSONALITY DISORDER*

PMHx: *(RELEVANT MEDICAL / DEVELOPMENTAL Hx)* ☐ *ADDICTION + MENTAL HEALTH CONSULTS, DISCHARGE SUMMARIES, LABS, ETC. ATTACHED*

| MEDICATIONS + OTC ☐ *MEDICATIONS ATTACHED* | DOSAGE / FREQUENCY | CURRENT | USED TO TREAT |
|---|---|---|---|
| | | ☐ YES ☐ NO | |
| | | ☐ YES ☐ NO | |
| | | ☐ YES ☐ NO | |
| | | ☐ YES ☐ NO | |
| | | ☐ YES ☐ NO | |

| PHARMACY | ALLERGIES ☐ *NKA* |
|---|---|

| AGENCIES, HOSPITALS, OR THERAPIES PATIENT ATTENDED IN LAST TWO YEARS | ORGANIZATION | DESCRIBE INVOLVEMENT |
|---|---|---|
| | | |
| | | |
| | | |

## ADDICTION SPECIFIC INFORMATION

WHAT STAGE OF CHANGE IS THE PATIENT IN? ☐ PRECONTEMPLATION ☐ CONTEMPLATION ☐ PREPARATION ☐ ACTION ☐ MAINTENANCE

HAS THE PATIENT HAD A UDS OR BREATHALYZER IN PAST 30 DAYS? IF YES, DETAILS: ☐ *LABS ATTACHED*

IS THE PATIENT ON OAT? *(METHADONE/SUBOXONE):* ☐ YES ☐ NO — IF NO CONTINUE TO GROUP SUITABILITY

OAT PROVIDER ☐ *SAME AS REFERRING HEALTH PROFESSIONAL*

| PHONE OR E-MAIL | CLINIC |
|---|---|

| OAT MEDICATION TYPE | DOSAGE / FREQUENCY | DISPENSE SCHEDULE *(DWI / CARRIES)* |
|---|---|---|
| | | |

DISPENSING PHARMACY ☐ *SAME AS PHARMACY ABOVE*

*** PLEASE BE AWARE GARUDA CENTRE PROGRAMS DO NOT PROVIDE OAT OR ROUTINE MEDICAL MANAGEMENT ***
*** IF PATIENT IS ALREADY ON A STABLE DOSE OF OAT BUT DOES NOT HAVE A COMMUNITY PROVIDER, WE CAN RECOMMEND OPTIONS ***

## GROUP SUITABILITY

*PLEASE CONFIRM THIS PATIENT IS NOT IN ACTIVE WITHDRAWAL AND APPROPRIATE FOR GROUP BASED LEARNING + EXERCISE, IN THE EVENT OF UNCLEAR GROUP SUITABILITY ADDITIONAL INFORMATION MAY BE REQUESTED*

- ☐ IS NOT COGNITIVELY IMPAIRED
- ☐ NO SUBSTANCE / ALCOHOL USE *(MIN 1 MON.)*
- ☐ DOES NOT HAVE ACTIVE PSYCHOSIS
- ☐ DOES NOT HAVE A HISTORY OF VIOLENT BEHAVIOUR OR SAFETY CONCERNS
- ☐ HAS NOT HAD ACTIVE PTSD FOR PAST 6 MONTHS *(FLASHBACKS, DISSOCIATION)*
- ☐ DOES NOT HAVE CRIMINAL / LEGAL ISSUES PENDING
- ☐ DOES NOT HAVE A DISORDER THAT COULD INTERFERE WITH GROUP LEARNING + EXERCISE (E.G. PD)
- ☐ IS NOT AT-RISK FOR SELF-HARM, (INCLUDING SUICIDE + ACTIVE IDEATION)
- ☐ MEDICALLY CLEARED FOR RIGOROUS EXERCISE + GROUP SESSIONS
- ☐ UNDERSTANDS THIS IS A 90 DAY COMMITMENT: 90 MIN GROUP + 90 MIN EXERCISE 3 DAYS A WEEK, + 30 MIN. DAILY HOME PRACTISE

PLEASE DESCRIBE IF PATIENT DOES NOT MEET ALL GROUP SUITABILITY CRITERIA, *OR ADD ADDITIONAL COMMENTS*

## COMPLETED BY

*WE REQUEST THE REFERRING CLINICIAN BE AVAILABLE TO THE PATIENT FOR THERAPEUTIC SUPPORT IF NECESSARY*
*OUR PROGRAMS CANNOT PROVIDE EMERGENCY OR ADDITIONAL SESSIONS OF SUPPORT*

| NAME + CREDENTIALS | SIGNATURE | DATE OF COMPLETION *DD/MM/YYYY* |
|---|---|---|
| | | |

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Clear Consent Form

# CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

**PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)**

I,

PATIENT NAME

AUTHORIZE

HEALTHCARE PROVIDER/CLINIC

TO DISCLOSE MY PERSONAL HEALTH INFORMATION CONSISTING OF:

☐ LAB + TEST RESULTS ☐ PATIENT SUMMARY SHEET ☐ DISCHARGE SUMMARIES ☐ PSYCHOLOGICAL REPORTS
☐ PREVIOUS ADDICTION/PSYCHIATRIC CONSULTATIONS ☐ MEDICATION LISTS ☐ ALL OF THE ABOVE ☐ OTHER

IF OTHER PLEASE DESCRIBE PERSONAL HEALTH INFORMATION TO BE DISCLOSED

TO

Dr. Álvarez de Lorenzana and Garuda Centre Clinical Staff

AND CONSENT TO HAVE GARUDA CENTRE STAFF INQUIRE OR CONSULT WITH MY HEALTHCARE PROVIDER(S) AND PHARMACIST ON ANY MEDICAL NEEDS OR CONCERNS WHILE I AM IN TREATMENT

PHARMACIST NAME AND/OR ADDRESS

DOES NOT HAVE PHARMACIST ☐

☐ I UNDERSTAND THE PURPOSE FOR DISCLOSING THIS PERSONAL HEALTH INFORMATION TO THE PERSON(S) NOTED ABOVE.

☐ I UNDERSTAND THAT I CAN REFUSE TO SIGN THIS CONSENT FORM.

MY NAME

MAILING ADDRESS

| DATE *DD/MM/YYYY* | TELEPHONE | SIGNATURE |
|---|---|---|
| | | |

HEALTHCARE PROVIDER

NAME/CREDENTIALS

MAILING ADDRESS

| DATE *DD/MM/YYYY* | TELEPHONE | SIGNATURE |
|---|---|---|
| | | |