

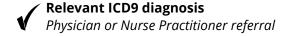
# **REFERRAL FORM**

#### **HOW TO SUBMIT REFERRAL**

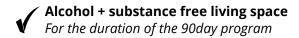
PLEASE SIGN + FAX COMPLETED FORM TO: 250 754 5245

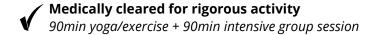
To help us provide the best care possible, please complete the Informed Consent section with the patient and include relevant documents, such as: patient medical summary sheet, previous addiction and/or psychiatric consultations, discharge summaries, medication lists, psychological reports, lab + test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

#### **GENERAL ADMISSION CRITERIA**









Community healthcare provider/clinic
For medical needs/concerns during the program

If on OAT has outside provider<sup>†</sup>
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

<sup>†</sup> 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.



PATIENT ID LABEL
(GARUDA CENTRE USE ONLY)

## **REFERRAL FORM**

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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	CLINIC					
REFERRAL DATE DD/MM/YYYY  PHONE				** FAX **	** FAX **		LLING JMBER			
REFERRING H	REFERRING HEALTHCARE PROFESSIONAL: PHYSICIAN NURSE PRACTITIONER OTHER:									
EMAIL	EMAIL SELECT REHAB AFTERCARE FOR MEN (RAM) REHAB AFTERCARE FOR WOMEN (RAW)									
PATIENT INFORMATION										
PATIENT NAM	PATIENT NAME  DATE OF BIRTH DD/MM/YYYY  PHN									
AGE	GE GENDER PHONE				** EMAIL **					
CON	SENT TO VOICE-MAIL ME	SSAGES:	YES NO	CONS	CONSENT TO E-MAIL COMMUNICATION: YES NO					
MAILING ADI	DRESS									
EMERGENCY + RELATIONS					PHONE					
FAMILY PHYS	ICIAN					SAME .	AS REFERRING HEALTH PROFESSIONAL			
PHONE	**	AX **		CLINIC						
REASON FOR	REFERRAL - CURRENT P	ROBLEMS A	AND Hx + SUBSTAN	CE USE, AMOUNT,	FREQUENCY		OR, HX ATTACHED			
DIAGNOSIS A	ND 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										

GARUNA (FKI+RF

JANGULAN (ZINTRZ											PAGE 2/2
MEDICATIONS + OTC	OTC MEDICATIONS ATTACHED DOSAGE			JENCY	CURRENT			USED TO TREAT			AT
					YE:	s	NO				
					YES	s	NO				
					YES	S	NO				
					YES	 S	NO				
					YES	s	NO				
PHARMACY				ALLEF							NKA
AGENCIES, HOSPITALS, OR THERAPIES PATIENT ATTENDED IN LAST TWO YEARS				ORG	GANIZATION				DESCRIBE INVOLVEMENT		
		ADDICT	ION SPE	CIFIC IN	FORMAT	ION					
WHAT STAGE OF CHANGE IS THE PATIENT IN?	: PRECONTEMPL	ATION	CON	TEMPLAT	ION	PR	REPARATIO	ON	ACTION	MAI	NTENANCE
HAS THE PATIENT HAD A UDS OR BREATHALYZER IN PAST 30 DAYS? IF YES, DETAILS:											
IC THE DATIENT ON OAT?	(METUADONE (CUDOVONE):		VE	<u> </u>	N.C		IF NO 60	AITIAILIE	TO CROUP	CUITADUU	T.V.
IS THE PATIENT ON OAT? (METHADONE/SUBOXONE):  YES  NO — IF NO CONTINUE TO GROUP SUITABILITY							1 T				
OAT PROVIDER								SAN	IE AS REFERR	ING HEALTH	PROFESSIONAL
PHONE OR E-MAIL			(	CLINIC							
OAT MEDICATION TYPE			DOSAGE	/ FREQU	IENCY	DIS	SPENSE S	CHEDULE	(DWI / CAR	RIES)	
DISPENSING PHARMACY										SAME AS PH	ARMACY ABOVE
** 0.5455	DE AWARE CARURA CENT	.0.5 00000		NOT DDG	N//DE 047		DOUTING			A45A17 **	

\*\* 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 DOES NOT HAVE A HISTORY OF VIOLENT BEHAVIOUR OR SAFETY CONCERNS

DOES NOT HAVE A DISORDER THAT COULD INTER-FERE WITH GROUP LEARNING + EXERCISE (E.G. PD)

NO SUBSTANCE / ALCOHOL USE (MIN 1 MON.) HAS NOT HAD ACTIVE PTSD FOR PAST 6 MONTHS (FLASHBACKS, DISSOCIATION)

IS NOT AT-RISK FOR SELF-HARM,

(INCLUDING SUICIDE + ACTIVE IDEATION)

DOES NOT HAVE ACTIVE PSYCHOSIS DOES NOT HAVE CRIMINAL

/ LEGAL ISSUES PENDING

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

A-617 WENTWORTH STREET, NANAIMO BC

P. +1 250 754 3686

F. +1 250 754 5245

GARUDACENTRE.COM

INFO@GARUDACENTRE.COM



### **CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION**

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

PATIENT NAME							
AUTHORIZE							
HEALTHCARE PROVIDER/CLINIC							
TO DISCLOSE MY PERSONAL HEALTH INFORM	NATION CONSISTING OF:						
LAB + TEST RESULTS PATIE	NT SUMMARY SHEET DISCH	ARGE SUMMARIES	PSYCHOLOGI	CAL REPORTS			
PREVIOUS ADDICTION/PSYCHIATRIC C	ONSULTATIONS MEDICATION L	STS ALL OF	THE ABOVE	OTHER			
IF OTHER PLEASE DESCRIBE PERSONAL HEA	LTH INFORMATION TO BE DISCLOSED						
то							
Dr. Álvarez de Lorenzana and Ga	aruda Centre Clinical Staff						
AND CONSENT TO HAVE GARUDA CENTRE S AND PHARMACIST ON ANY MEDICAL NEEDS			)				
PHARMACIST NAME AND/OR ADDRESS		DOES NOT HAVE PHARMACIST					
I UNDERSTAND THE PURPOSE FOR D I UNDERSTAND THAT I CAN REFUSE T	SCLOSING THIS PERSONAL HEALTH INFO	RMATION TO THE PERS	SON(S) NOTED AB	OVE.			
MY NAME							
MAILING ADDRESS							
DATE DD/MM/YYYY	TELEPHONE	SIGNATURE					
HEALTHCARE PROVIDER		JL					
NAME/CREDENTIALS							
MAILING ADDRESS							
DATE DD/MM/YYYY	TELEPHONE	SIGNATU	RE				