

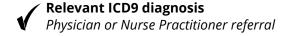
REFERRAL FORM

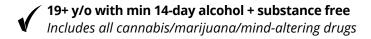
HOW TO SUBMIT REFERRAL

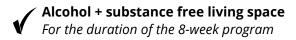
PLEASE SIGN + FAX COMPLETED FORM TO: 250 754 5245

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







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 8-week commitment 9h/wk

INFORMATION FOR REFERRING PROVIDERS

A physician or nurse practitioner referral is required for the Behavioural Medicine Aftercare Programs (BMAP) as they are billed 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 are 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.



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						
REFERRAL DATE DD/MM/YYYY PHONE				** FAX **			E N	BILLING NUMBER		
REFERRING HEALTHCARE PROFESSIONAL: PHYSICIAN				NURSE PRACTITIONER OTHER:						
EMAIL SELECT REHAB AFTERCARE FOR MEN (RAM) REHAB AFTERCARE FOR WOMEN (RAW)										
PATIENT INFORMATION										
PATIENT NAME DATE OF BIRTH DD/MM/YYYY PHN										
AGE	GENDER			** EMAIL **						
CONSENT TO VOICE-MAIL MESSAGES: YES NO				CONSENT TO E-MAIL COMMUNICATION: YES NO						
MAILING ADDRESS										
EMERGENCY + RELATIONS							PHONI	Ē		
FAMILY PHYSICIAN SAME AS REFERRING HEALTH PROFESSIONAL										
PHONE		** FAX **		CL	INIC					
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										

7 Q+1X73 ACIUQA.

GARGDA (ŁNTRŁ							PAGE 2/2		
MEDICATIONS + OTC MEDICATIONS ATTACHE	FREQUENC	Y CURR	ENT	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			
	ADDIC	TION SPEC	IFIC INFORMAT	ΓΙΟΝ					
WHAT STAGE OF CHANGE IS THE PATIENT IN? PRECONT	EMPLATION	CONT	EMPLATION	PREPARA	ATION	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		С	LINIC						
OAT MEDICATION TYPE		DOSAGE /	FREQUENCY	DISPENSE	SCHEDULE	(DWI / CARRIES	s)		
DISPENSING PHARMACY SAME AS PHARMACY ABOVE									
4.4									

** PLEASE BE AWARE GARUDA CENTRE PROGRAMS DO NOT PROVIDE OAT OR ROUTINE MEDICAL MANAGEMENT **

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 14 DAYS)

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 AN 8-WEEK 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

^{**} IF PATIENT IS ALREADY ON A STABLE DOSE OF OAT BUT DOES NOT HAVE A COMMUNITY PROVIDER, WE CAN RECOMMEND LOCAL OPTIONS **



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.	ATION CONSISTING OF:					
LAB + TEST RESULTS PATIEN	T SUMMARY SHEET DISCHA	ARGE SUMM	ARIES PSYCHOLOGI	CAL REPORTS		
PREVIOUS ADDICTION/PSYCHIATRIC CO	NSULTATIONS MEDICATION LIS	STS	ALL OF THE ABOVE	OTHER		
IF OTHER PLEASE DESCRIBE PERSONAL HEAL	TH INFORMATION TO BE DISCLOSED					
ТО						
Dr. Álvarez de Lorenzana and Ga	ruda Centre Clinical Staff					
AND CONSENT TO HAVE GARUDA CENTRE STA			ROVIDER(S)			
PHARMACIST NAME AND/OR ADDRESS		DOES NOT HAVE PHARMACIST				
I UNDERSTAND THE PURPOSE FOR DIS	CLOSING THIS PERSONAL HEALTH INFO	RMATION TO) THE PERSON(S) NOTED AB	OVE.		
MY NAME						
MAILING ADDRESS						
DATE DD/MM/YYYY	TELEPHONE	SIGNAT	ATURE			
HEALTHCARE PROVIDER						
NAME/CREDENTIALS						
MAILING ADDRESS						
DATE	TELEPHONE		SIGNATURE			
DATE DD/MM/YYYY	1-2 11-2					