MAPLE
Addiction Recovery Centres

1 800-542-1429
www.mapleaddictioncentres.ca
1 647-689-3887
wecare@mapleaddictioncentres.ca

Referral Form

Referring Dr: ____________________

CPSO: ____________________ Billing # ____________________

Agency/Source: ____________________

Address: ____________________

Phone # ____________________ Fax # ____________________

Patient information

Full Name: ____________________

DOB (mm/dd/yyyy): ____________________ Gender: ☐ Male ☐ Female

Health Card # ____________________ Version: __________ Expiry: __________

Address: ____________________ City: __________ Postal Code: __________

Phone # ____________________ Email: ____________________

Emergency Contact: ____________________

Reason for Referral:

- ☐ Opioid Addiction
- ☐ Cannabis Use Disorder
- ☐ Benzodiazepine Addictions
- ☐ Nicotine Addiction
- ☐ Alcoholism
- ☐ CBT

Location:

- ☐ Amherstburg
- ☐ Toronto
- ☐ Sarnia
- ☐ Chatham
- ☐ Harrowsmith

Psychiatric Consultation: ☐ Yes ☐ No

(Please attach any relevant information regarding psychiatric diagnosis, medical condition, medication etc.)

Risk Factors: ☐ Harm to self ☐ Harm to others ☐ Legal problem

Signature: ____________________ Date (mm/dd/yyyy): ____________________