

**ADDICTION MEDICINE CONSULT
Referral Form**

Client Information:

Patient Name: _____ Gender M ☐ F ☐

PHN: (Required) _____ DOB (mm/dd/yyyy): _____

Phone: (H) _____ (Mobile) _____ OK to leave message? Y N

Address: _____ Postal Code: _____

Reason for Referral/History of Present Illness:

Signature: _____, MD MSP# _____

Current Medications:

1. _____

3. _____

2. _____

4. _____

Past Psychiatric History/Addiction Treatment History:

Past Medical History:
