REFERRING MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BILLING #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR SIGNATURE :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DETAILS** (NAME, DOB, OHIP, PHONE, ADDRESS):

**REASON FOR REFERRAL:**

1. OPIATE MANAGEMENT

2. SUBSTANCE USE DISORDER (OPIODS/ALCOHOL)

3. MEDICAL MARIJUANA LICENSE

**INFORMATION THAT *MUST* BE INCLUDED FOR PATIENT TO BE SEEN:**

* CURRENT NARCOTIC LIST
* PAIN HISTORY (opiate management patients only)
* RELEVANT DIAGNOSTICS (opiate management patients only)
* TREATMENT GOAL : (please indicate one)
* TAPER
* OPIATE MEDICATION CHECK
* INADEQUATE PAIN CONTROL
* METHADONE / SUBOXONE

***NOTE:***

* **Substance Use Disorder patients will be seen the same or next day**
* **Patients *must* be currently taking narcotics to be seen (except alcohol use and medical marijuana license)**
* **$100 MISSED APPOINTMENT FEE (WITHOUT 24 HR NOTICE)**
* **GP Focused Practice Exemption for FHO Dr.’s Access Bonus**