

St. Michael's

Inspired Care.
Inspiring Science.

Addictions Consult Team

Date of referral: _____ Time: _____

Patient Name: _____ Contact number: _____

Name of person making referral: _____ Department: _____

REASON FOR REFERRAL: * Please check the boxes that apply

- Has substantial community problems resulting from substance misuse
- Is being admitted for medical complications of substance use
- Has no current addictions plan or worker in the community
- Has frequent visits to ED for related to substance use
- Advice/information regarding medical withdrawal and/or the role of medication in addictions treatment
- To assess appropriateness of patient for participation in concurrent disorders group (must have a diagnosed psychiatric disorder and existing psychiatric community care)
- PATIENT HAS GIVEN CONSENT FOR ADDICTIONS REFERRAL ******
- PATIENT WAS DISCHARGED BEFORE BEING SEEN BY ADDICTION TEAM (ADVISED TO SEE TEAM ON A DROP IN BASIS ANY WEEKDAY MORNING AT 10:00 AM TO THE 17 CARDINAL CARTER RECEPTION DESK)**

Things we cannot do....

- Transfer a patient to immediate residential treatment
- Provide a follow up from a psychiatrist or GP in the community (refer to CATCH)
- Assess a patient who has directly stated that they will not engage with Addiction Services
- Accept a referral for patients **only** wanting a withdrawal management bed
- Manage or provide direct care to patients requiring immediate medical detox (can be managed by the existing medical service)

Please fax referral to 5480