Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

Opioid Dependency Program/Narcotic Transition Services Referral

Please complete if you are a non-Connect Care provider/facility. Please include medications if not available on Netcare.

Client Demographics

Last Name	First Name	Middle Name
Personal Health Number	Date of Birth *(dd-Mon-yyyy)*	Gender & Pronouns

Address *(Apt/House # and Street Name)*	City	Province	Postal Code

Contact Phone Number ☐ Home ☐ Cell | Can staff leave a message? ☐ Yes ☐ No

Referral Information

Referring Provider	Clinic/Agency	Phone	Fax

Primary Care Provider	Date of Referral *(dd-Mon-yyyy)*	Priority ☐ Routine ☐ Urgent ☐ Pregnant

Interpreter Required ☐ Yes ☐ No | Primary Language

Reason for Referral

Requested Service
☐ OAT
☐ Psychiatry
☐ Other _____
☐ NTS *(Eligibility to be determined by the receiving provider)*
☐ Withdrawal Management

Substance Use History

Substance	Current Use	Route	Last Use	Comments
Opioids				
Methamphetamine				
Alcohol				
Benzodiazepines				
Cocaine/Stimulants				
Cannabis				
Other:				

Drug poisoning / naloxone use: ☐ Yes ☐ No | Previous treatment / OAT History

Withdrawal history / seizures: ☐ Yes ☐ No | Medical History:

Mental Health History

Completed By

Name *(Print)*	Signature	Designation	Date *(dd-Mon-yyyy)*