Pine Lodge Addiction Recovery Inc - Referral Form

Client Information

Client Name: _____ DOB: _____ HSN: _____

Phone number: _____ Gender: _____

Address: _____ City: _____ Province: _____

Family Physician: _____

Referral Contact Information

Referring Person: _____ Referring Contact: _____

MH/Addictions Counsellor: _____ Contact: _____

Substance Use History

Date of Last Use: _____ ☐ Accurate ☐ Approximate

Substance(s) of Choice: _____ Other Substances Used: _____

Other Information

Education Level: _____

Finances: ☐ Has ☐ Needs Housing: ☐ Has ☐ Needs

Pregnant: ☐ No ☐ Yes _____ Concerns: _____

Child & Family Service Worker: _____ Contact: _____

Visit Scheduled: ☐ No ☐ Yes Visit Date: _____

Legal Involvement: ☐ No ☐ Yes Court Date: _____

Probation or Parole Officer: _____ Contact: _____

Designated Support Person

Name: _____ Contact: _____ Relation: _____

Supplemental Info

☐ Client has given consent for referral form to be submitted

It is an expectation that client's will be coming straight from Detox to Treatment facility.
ATC staff will make treatment facility aware if client leaves Detox prior to date.