

Referral Form

Name of client/patient: LAST NAME, FIRST NAME		Date:
DOB:	Age:	
Telephone Number:	<input type="checkbox"/> Call OK? <input type="checkbox"/> Message OK?	
Reason for Referral: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Name of person completing this referral: _____		
This person consents to receiving contact from Richmond Addiction Services.		
Signed: _____		

To be filled out by RASS Staff:
Follow-Up: <hr/>
Results: <hr/>

Thank you! These requests are processed Tuesday to Friday and an intake counsellor will follow up within one business day.

CONFIDENTIALITY WARNING

The documents accompanying this transmission contain confidential information intended for a specific individual and purpose. The information is private and is legally protected by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. Thank you.