HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

COMMUNITY WITHDRAWAL MANAGEMENT REFERRAL
WITHDRAWAL MANAGEMENT SERVICES

Date: _____ (MM/DD/YYYY) _____

Please Print

Referral Source: _____

Does the client meet Admission Criteria? ☐ Yes ☐ No

Name: _____

Gender: _____ Date of Birth: _____ (MM/DD/YYYY) _____

Address: _____

Telephone: _____ Consent to Contact: ☐ Yes ☐ No

Healthcard Number: _____

Emergency Contact: _____

Mental Health Diagnosis (if known): _____

Medications: _____

Substance(s) Used: _____

Frequency/Duration: _____

Route: _____

Psychiatrist and Family Doctor/Nurse Practitioner: _____

Reason for Referral: _____

Community Withdrawal Management Contact Information Given: ☐ Yes ☐ No

Please Fax to: 519-253-1752