CROSSROADS NORTH
HOPE · HEALING · RECOVERY

Referral Form

Patient Information

Given Name: _____ Last Name: _____

Preferred Name: _____ Gender: _____ DOB *(m/d/y)*: _____

Health Card Number _____ Version Code ____ ____

Best way to contact patient: _____

Clinical Information

Please check ALL of the patient's needs that require addiction care and services. Please include details where possible.

☐ Mental health: _____

☐ Substance use: _____

☐ Other: _____

Medications: _____

Comments: _____

Referral Source

Clinician Name: _____

Agency Name *(if applicable)*: _____

Contact: _____

Please fax completed forms to (226) 383-8572

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Fergus, ON, N1M 1E7

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Fax: 226-383-8572

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