

Physician Referral Form

Referral destination

Dr Bazza, MD, CCFP - Family Physician (Focused Practice)

Consultation and stabilization in complex care: mental health, addiction, chronic pain, and medication complexity.

Clinic / Program fax

Date sent

Referring clinician / clinic

Referral contact phone / fax

1. Patient Information

Patient name

PHN / ULI

DOB

Patient phone

Current pharmacy

Current primary prescriber

2. Reason for Referral

- | | | |
|--|--|--|
| <input type="checkbox"/> Opioid complexity | <input type="checkbox"/> Benzodiazepine / Z-drug | <input type="checkbox"/> OAT / addiction |
| <input type="checkbox"/> Chronic pain / fibromyalgia | <input type="checkbox"/> Mental health complexity | <input type="checkbox"/> Functional / somatic disorder |
| <input type="checkbox"/> Polypharmacy / co-sedation | <input type="checkbox"/> Disability function support | <input type="checkbox"/> Other |

Specific referral question / requested assistance

3. Requested Service Type

- | | | |
|--|---|--|
| <input type="checkbox"/> Advice only | <input type="checkbox"/> Temporary stabilization | <input type="checkbox"/> Assistance with taper |
| <input type="checkbox"/> OAT initiation / optimization | <input type="checkbox"/> Medication safety review | <input type="checkbox"/> Shared-care plan |

4. Key Risk Concerns

- | | | |
|--|--|--|
| <input type="checkbox"/> Early refill requests | <input type="checkbox"/> Sedation / cognitive impairment | <input type="checkbox"/> Falls / driving concern |
| <input type="checkbox"/> Dose escalation | <input type="checkbox"/> Substance use concern | <input type="checkbox"/> Overdose risk |
| <input type="checkbox"/> Lost / stolen medications | <input type="checkbox"/> Multiple prescribers/pharmacies | <input type="checkbox"/> None known |

Brief clinical summary and risk context

Referral Details and Attachments

5. Current Medication Information

Current medications relevant to referral (or attach medication list)

Last opioid/benzo/z-drug prescription date, if relevant

Current dispense pattern, if known

6. Function-Focused Referral Information

What is the patient unable to do now that they want to be able to do?

- | | | |
|---|--|--|
| <input type="checkbox"/> Work/productivity impaired | <input type="checkbox"/> ADLs impaired | <input type="checkbox"/> Sleep impaired |
| <input type="checkbox"/> Physical function impaired | <input type="checkbox"/> Social/relationship function impaired | <input type="checkbox"/> Disability forms/support needed |

7. Relevant History / Investigations

Pertinent diagnoses, previous treatments, investigations, or barriers to care

8. Attachments Requested

- | | | |
|---|---|--|
| <input type="checkbox"/> Medication list | <input type="checkbox"/> Recent labs | <input type="checkbox"/> Relevant imaging/reports |
| <input type="checkbox"/> Problem list / PMH | <input type="checkbox"/> Prior consultant notes | <input type="checkbox"/> UDS/PMP/TPP info if available |

9. Urgency / Safety

- | | | |
|----------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Routine | <input type="checkbox"/> Semi-urgent | <input type="checkbox"/> High safety concern - please specify |
|----------------------------------|--------------------------------------|---|

Urgency explanation / immediate safety concerns

--

10. Referral Acknowledgement

I understand this is a consultation and time-limited stabilization service. Referral does not imply automatic prescribing takeover, automatic continuation of controlled medications, or replacement of ongoing primary care. Urgent or emergent concerns should be directed to ED/urgent services.

Referring clinician signature

Date

--	--