Please fax this completed form to:
1-844-941-1983

ASCO Medical Referral Form

REFERRAL DATE (MM/DD/YYYY)	

PREFERRED ASCO CLINIC FOR REFERRAL (OPTIONAL)	

Please note that clients may be seen at a different ASCO clinic based on their location and availability

CLIENT INFORMATION

Legal Name
First Name: ______________________ Last Name: ____________________

Preferred Name (If applicable): ______________________________________

Date of Birth (mm/dd/yyyy):

Gender:

Pronoun:

Address
Street: ____

Unit #: __________ City: ______________ Postal Code: ____________

Health Card Information

Health Card # **:** ____________________
Version Code**:** ________
Expiry date (mm/dd/yyyy): ______________

Contact Information
By listing telephone numbers and an email below, the referral source confirms that the client consents to ASCO to communicate with them regarding this referral.

Telephone: ___________________________ Email: ____________________________________

Consents to receive voicemails/texts: ______ Is an interpreter needed? If so, please state language: __________________________

REASON FOR REFERRAL

Assessment & Ongoing Care   One Time Consult

Please indicate the primary reason for referral (substance use, quantity, withdrawal, client goals)

Current Medications

Relevant Medical/Psychosocial/Developmental History (Please attach any consult notes, labs, reports)

REFERRING PROVIDER INFORMATION

Name:

Designation:

Billing #:

Address:

Telephone:

Fax:

Email:

Signature: