Providence Health Care
Crosstown Clinic

Crosstown Referral: Acute Referral

Crosstown Clinic, located at 77 East Hastings, supports those who are located in the PHC/VCH area to access Injectable Opioid Agonist Treatment (iOAT). Our multidisciplinary team provides iOAT titration and maintenance. If the client transitions to an alternate form of OAT, the ongoing treatment will be transferred to a community OAT prescriber. This referral form must completed with the client for consent and awareness that the treatment provided will include accessing the clinic in person up to three times a day. Crosstown Clinic does not have the capacity to provide ongoing Primary Care, but we can support client referrals to a community resource when required.

The following information is mandatory, incomplete referrals will be returned. There are two parts to this referral form, one to be completed with the client and one part for referral agent only. Please fax completed referral form to Crosstown Clinic: 604 689-3996. We no longer accept referrals over the phone.

Client Name: _____ DOB: _____

PHN: _____ Contact Number (if available): _____

Identified Gender: _____ Pronouns used: _____

Identified Ethnicity: _____

Referrer Name/Title: _____ Dept./Site _____

Phone: _____ Fax: _____

Who should we contact for referral follow up? (Name and Phone Number)

_____

Reason for Referral: _____

_____

_____

_____

_____

_____

77 E Hastings Street
Vancouver, BC Canada V6A 2R7
T: 604-689-8803 **F:** 604-689-3996
providencehealthcare.org

Sites
St. Paul's Hospital
Holy Family Hospital
Mount Saint Joseph Hospital
Youville Residence
St. John Hospice
St. Vincent's: *Brock Fahrni, Langara, Honoria Conway–Heather*
Crosstown Clinic

Community Dialysis Clinics
East Vancouver
North Shore
qathet Powell River
Richmond
Sechelt
Squamish
Vancouver

Please complete WITH the client:

- What is your primary drug of choice: _____
- Preferred method of ingestion: _____
  - How many days per week: _____ How many times per day: _____
- Are you injecting opioids: Yes _____ No _____
  - How many days per week: _____ How many times per day: _____
- Are you using:
  - Stimulants: Yes _____ Approximate Daily Usage _____ No _____
  - Benzodiazepines: Yes _____ Approximate Daily Usage _____ No _____
  - Alcohol: Yes _____ Approximate Daily Usage _____ No _____
- Crosstown's mandate is to provide injectable prescription Heroin (diacetylmorphine) or Dilaudid (hydromorphone). Are you willing to engage in this treatment? Yes _____ No _____
- Are you willing to come to the clinic 2-3 times per day? Yes _____ No _____
- Are you able to attend the clinic independently? Yes _____ No _____
  - If no, what supports are required: _____

    _____

    _____
- Do you have a family doctor, NP or a clinic that you regularly attend: No _____ Yes_____
  - If yes, please specify: _____

    _____
  - Are there any current ongoing medical concerns? _____

    _____
  - List your current medications: _____

    _____
  - Do you have any current open wounds? No_____ Yes_____

    Details: _____

    _____
  - Who monitors the wounds? _____

    _____

- Do you have a current OAT prescriber: No _____ Yes_____
  - Prescriber's name: _____
  - Clinic name: _____
  - Contact Number: _____

    _____
  - List of current Opiate Antagonist Therapy: _____

    _____

    _____
  - List of current Safe Supply (if applicable):_____

    _____

    _____
- Are you connected to other community supports (i.e. Outreach, ACT): No _____ Yes_____
  - If yes, please specify: _____
- Are you connected to a community mental health team? No _____ Yes_____
  - Team's name: _____
  - Contact Number: _____

    _____
- Do you have a current fixed address: No_____ Yes_____
  - If Yes, please specify: _____

    _____
  - If No, please specify: _____

    _____
- Do you have access to any regular financial resources: No_____ Yes_____
  - If Yes, please specify: _____

    _____
- Do you have British Columbia ID: No_____ Yes: _____

Consent to release information

I hereby authorize:

(Name of agency, organization, person, clinic)

To release my medical, health, or other information relevant to my care, to Providence Health Care Authority, for the purposes of receiving services from Crosstown Clinic.

- I confirm the information in this referral and any supporting documentation are accurate to the best of my knowledge.
- I give permission to Crosstown Clinic to access my electronic medical records, including medinet, for continuity of care.
- I give consent for Providence Crosstown Clinic physicians and staff to contact my Provider/ clinic below who are involved in my medical care to discuss ongoing care:

Practitioner Name: _____

Clinic Name: _____ Phone: _____

Client Signature: _____ Date: _____

Client Name: _____

To be completed by Referral agent only:

- Reason for current hospital visit:

  _____

  _____

  _____

- Any relevant discharge follow up the clinic needs to be aware of? (i.e., IV Abx, Home support. etc.)

  _____

  _____

  _____

- Are there any known safety risk factors? (i.e., Violence and/or Aggression)

  _____

  _____

  _____

- Have there been any known incidences of violence in the last 6 months?

  _____

  _____

  _____

- In the last 2 years, has there been any serious criminal justice involvement? (i.e., direct harm towards others, assault charges, sexually driven assaults/charges, etc.)

  _____

  _____

  _____

Please include AMCT/Addictions consult/Social Work consult and any relevant collateral (i.e. discharge summary)