Providence Health Care
Crosstown Clinic

# Crosstown Clinic Referral: Community Pathway

*****The following information is mandatory, Incomplete Referrals will be returned*****

Please fax completed referral form to Crosstown Clinic: 604 689-3996

Client Name:_____ DOB:_____

PHN:_____ Contact Number (if available):_____

Referrer Name/Organization: _____Clinic: _____

Relationship (i.e. MRP)_____

Phone: _____Fax: _____

## Please complete WITH your client:

- ☐ What is your primary drug of choice: _____
- ☐ Are you injecting opioids most days: Yes _____ No _____ If no, approx. how often _____
- ☐ Are you interested in injectable safe supply or treatment: Yes _____ No _____
- ☐ Would prescription IV Heroin(diacetylmorphine) or IV Dilaudid (hydromorphone) be acceptable treatment: Yes_____ No_____
- ☐ For this treatment to work people need to come in to the clinic 2-3 times per day, every day. Are you willing to do that: Yes _____ No _____

**Our clinic is at 77 East Hastings Street. (In the DTES on the corner of Columbia and Hastings) **

- ☐ Are you comfortable accessing services in this neighborhood: Yes _____ No_____
- ☐ Are you able to do this 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: _____

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

Do you have an OAT prescriber: No_____ Yes _____

If yes, please specify: _____

- Are you connected to other community supports (i.e. Outreach, ACT): No _____ Yes_____
  - If Yes, please specify: _____
  1.
- Do you have a current address: No_____ Yes_____
  - If Yes, please specify:_____
- DO you have access to any financial resources: No_____ Yes_____
  - If Yes, please specify:_____
- Do you have ID: No_____ Yes: _____
- Do you have any other social worker needs: No_____ Yes:_____
  - If yes, please specify:_____
- Do you use:
  - Stimulants: Yes _____ Approximate Daily Usage _____ No _____
  - Benzodiazepines: Yes _____ Approximate Daily Usage _____ No_____
  - Alcohol: Yes _____ Approximate Daily Usage _____ No _____
- Complex Wounds
  - Does client have complex wounds? No_____ Yes_____
  2. Details: _____
  - Connected to community resources for ongoing wound care?
  3. No_____ Yes_____
  4. Please Specify where: _____
  5. ****Please note we do not have capacity to do any wound care****

## Please include any substance use consults or summaries available.

**The care provided at Crosstown is supplemental to primary care, so the client will need to stay connected to their current provider. We will take on the responsibility of providing iOAT and OAT only until the client no longer needs specialized care or reaches stability on oral OAT at which point prescribing will be transferred back to the primary care provider.**

Please confirm that you agree with this process: Yes _____ No _____

If no, please specify why:_____

Client consents to this referral? Yes _____ No _____