**Bridges Medical Clinic is an addiction treatment clinic focusing on patients who are in process of entering, or have completed an addiction treatment program.**

**PATIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | First Name | Last Name | Last Name |
| Date of Birth | Birthday | OHIP#and version code | OHIP# and Version Code | Sexas on OHIP card | Sex | Gender(preferred) | Gender |
| Mobile Phone | Cell Phone | E-Mail | e-mail |
| Your patient will be contacted directly using the above information***. Please be sure to include direct and up-to-date contact information for the patient, especially mobile phone and e-mail address.*** |

**REFERRER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Name | Name | Clinic/Institution*if applicable* | clinic/hospital/group |
| Address | Address | Fax | Fax |
| Phone | Phone | Billing Number*if applicable* | Billing Number | E-Mail | E-Mail |

|  |  |
| --- | --- |
| What is the expected date of discharge? | Click or tap to enter a date. |

**If patient is currently in residential treatment:**

**PATIENT MEDICAL HISTORY**

|  |
| --- |
| Primary Diagnosis/Medical and Psychiatric History |
| Click or tap here to enter text. |
| Medications: |
| Click or tap here to enter text. |
| Are there any occupational, employment, court, medical/legal, custody, or other relevant concerns? Please explain briefly. |
| Click or tap here to enter text. |

|  |  |
| --- | --- |
| Date | date |

**Signature** Type Signature 

 *Type signature, enter signature image, or print and sign.*