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Providence HEALTH CARE

RAPID ACCESS ADDICTION CLINIC (RAAC) REFERRAL

Rapid Access Addiction Clinic (RAAC) – St. Paul's Hospital
2C-210 1081 Burrard Street, Vancouver, BC V6Z 1Y6
Phone: 604-806-8867 Fax: 604-297-9678
www.providencehealthcare.org

Date of Referral: _____

Client name: _____ _____
Last name First name Preferred pronouns

Preferred name/Alias: _____ Gender: ☐ Male ☐ Female ☐ Other: _____

DOB: (dd/mmm/yyyy) _____ PHN: _____

Primary care provider: _____

Contact information∗: Client phone: _____

Best way to contact client: _____

∗If client has no fixed address and no phone, provide alternate contacts and/or areas frequented for Outreach Team referral, or ask client to report to clinic for a walk-in assessment.

REFERRAL SOURCE:

Physician/NP name: _____ MSP No: _____

Agency Name: _____

Contact Name: _____

Contact Number: (required) _____

RAAC is accepting referrals for substance use management and treatment only. We do not provide primary care, chronic pain management, or mental health treatment. We will see patients for concurrent chronic pain and substance use disorder. Indicate below if client is interested in Hep C evaluation/treatment.

REASON(S) FOR REFERRAL: Provide relevant details for requested service.

☐ Substance use _____

☐ Hepatitis C evaluation/treatment _____

Relevant history / Additional information: _____

☐ Health concerns ☐ Mental health concerns _____

Eligibility will be assessed based on the above criteria. Clients will be contacted directly to book an appointment if eligible.

Fax completed referral to 604-297-9678

For Office Use Only	
Referral received: (date)	☐ RAAC ☐ VCC
Review initiated: (date)	**Referral declined:** ☐ Does not meet mandate
Status of review:	☐ Outside service area
Initial intake booked: (date)	☐ Other:
Referral source notified: ☐ Yes ☐ No – Reason:	