Referral of Shared Care Patient to

Clinic:		**Phone:**
Case Manager:		**Fax:**
Date:		
Referring Prescriber's Name:		**Phone:**
Practice Name:		**Fax:**
Patient Name:		
D.O.B:		**Phone:**

Reason for Referral:

- ☐ Dose adjustment assessment – increase/decrease (please select)
- ☐ Decline in mental health
- ☐ Increased or new substance use
- ☐ Behaviour/program compliance
- ☐ Other

Comments:

Please attach any relevant pathology/assessment results