E A S T K O O T E N A Y A D D I C T I O N S E R V I C E S S O C I E T Y

Medically Assisted Therapy Intake Form

First Name	**Last Name**	
Personal Health Care Number	**Birth Date (month/day/year)**	**Gender**
Street Address, Box Number, City and Postal Code		
Primary Phone Number	**OK to leave a message at this number?** ☐ Yes ☐ No	
Alternate Phone Number	**OK to leave a message at this number?** ☐ Yes ☐ No	
Email Address	**OK to contact you at this email?** ☐ Yes ☐ No	
Family Physician/Nurse Practitioner		

Are you concerned about?

□ Your own substance use □ Someone else's substance use

If you are here for your own use, what substance or substances are you most concerned about presently?

□ Prescription opioids □ Heroin/Illicit Fentanyl □ Benzodiazepines □ Alcohol
□ Cocaine □ Marijuana □ Crystal meth □ Amphetamines
□ Other:

Reason for Referral?

Mental Health Concerns?

□ Depression □ Anxiety □ ADHD □ Bipolar
□ Borderline Personality □ OCD □ Schizophrenia □ Psychosis
□ Other:

What are your goals or expectations for accessing the Medically Assisted Therapy Program?

* Some referrals require a physician refferal
* For drop in or rapid acess care please call,
Interior Health Urgent Responce Care Clinic. 250-420-2323

Client Signature ____________________ **Date** ____________________

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