

Aspen Reach – Sublocade Clinic

Healthcare Provider Referral Form

Patient Information

- First name: _____
- Last name: _____
- Date of birth (YYYY-MM-DD): _____
- PHN _____
- Preferred contact phone: _____
- Preferred contact email: _____

Eligibility

Please check all that apply (must meet all 3 criteria):

- ☐ Patient is currently taking buprenorphine (at least one dose on date of referral)
- ☐ Patient is interested in once-monthly injectable treatment (Sublocade) for opioid use disorder.
- ☐ Patient not currently using benzodiazepines, no active alcohol use disorder

Referring Provider Information

- Referring provider name: _____
- MSP Billing number: _____
- Provider fax (if applicable): _____

Clinical Information

- Primary diagnosis / reason for referral:
☐ Opioid use disorder

Referring provider signature: _____ Date: _____

FAX FORM TO (604) 398-5990 .