Physician Referral Form

Toll Free Phone: 1-888-282-7763
Toll Free Fax: 1-844-320-9652
www.cmclinic.ca

Patient Information:

Name: ____________________ DOB: ____________ Health Card # ____________________

Address: ____________________ City: ____________ Postal Code: ______________

Phone: (W) __________________ (H)______________ (C) ________________

Email *(required)*: ____

Referral to Service:

□ Assess suitability for Medical Cannabis □ Other ______________________________

□ YES □ NO Is patient taking anti-coagulants?

□ YES □ NO Is the patient pregnant, or trying to become pregnant?

□ YES □ NO Does the patient have a significant communicable disease? (HIV, Hepatitis, ect.)

□ YES □ NO Does the patient have untreated substance abuse/addiction?

Systemic/Other:

□ Chronic pain: iatrogenic, operative, post traumatic

□ Immunological condition (specify)_________________

□ Inflammatory Polyarthropathy (RA, Gout, other arthritis)

□ Neurodegenerative disease (specify)______________

□ Has the patient been assessed by a Pain Specialist, Neurologist, Rheumatologist or Oncologist

□Cancer (specify)___________________

□ Osteoarthritis

□ Spondyloarthropathy

□ Fibromyalgia

□ Neuropathic Pain

□ Other:___________________________

Mental Health:

□ Anxiety/Depression □ PTSD □ Sleep disorder

□ Has the Patient been assessed by a Psychiatrist, GP/Psychotherapist or Clinical Psychologist?

Current Medications:

____

Medications tried for current condition:

____

Physician Information:

Are you a member of a FHO/FHN/FHT? (Ontario Physicians ONLY) □ **YES** □ **NO**

Referring Physician or Nurse Practitioner: __________________________ (Please Print)

Referring Physician Designation: □ FRCPSC □ FRCPC □ CCFP □ Other: ____________________

Referring Physician/Nurse Practitioner Signature: ___________________________ **Date:** _________________

Phone: _______________ Fax: _______________ **Billing#** _________________

Please Select a Clinic:

□ Ontario Telehealth Network

□ Toronto, ON (Albany)
□ Toronto, ON(Eglinton)
□ Mississauga, ON
□ Milton, ON
□ Brampton, ON
□ Vaughan, ON

Please attach any relevant medical history, all pertinent scans/imaging and any pertinent consults from other physicians or specialists. Patients will NOT be seen without this information.