

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 Cancer (specify) _____
- Immunological condition (specify) _____ Osteoarthritis
- Inflammatory Polyarthropathy (RA, Gout, other arthritis) Spondyloarthropathy
- Neurodegenerative disease (specify) _____ Fibromyalgia
- Has the patient been assessed by a Pain Specialist, Neurologist, Rheumatologist or Oncologist 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

- Barrie, ON Hamilton, ON Ottawa, ON St. Catharines, ON
- Bracebridge, ON Kingston, ON Owen Sound, ON Stoney Creek, ON
- Burlington, ON London, ON Sarnia, ON Windsor, 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.