



**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:**

**Referring Physician or Nurse Practitioner:** \_\_\_\_\_ (Please Print)

**Referring Physician Designation:**  FRCPSC  FRCPC  CCFP  Other: \_\_\_\_\_

**Referring Physician/Nurse Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Billing#** \_\_\_\_\_ **Prac.ID#** \_\_\_\_\_

**Please Select a Clinic:**

- Telemedicine
- Chilliwack, BC  Kelowna, BC  Surrey

**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.**