CANABO MEDICAL CLINIC
A Division of Aleafia Heath Inc.

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:

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

□ Calgary, AB □ Edmonton, AB □ Winnipeg, MB

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.