Physician Referral Form

Toll Free Phone: 1-888-282-7763
Toll Free Fax: 1-844-320-9652
www.canabomedicalclinic.com

Patient Information:

Name: ______________________ DOB: ____________ Health Card # ____________________

Address: ____________________ City: ____________ Postal Code: ______________

Phone: (H)____________________ (C)______________ (W)____________________

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 an 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 location: ☐ **Telemedicine**

☐ **Calgary, AB**	☐ **Edmonton, AB**	☐ **Barrie, ON**	☐ **Bracebridge, ON**	☐ **Hamilton, ON**
☐ **Kingston, ON**	☐ **London, ON**	☐ **Ottawa, ON**	☐ **Brampton, ON**	☐ **Vaughan, ON**
☐ **Toronto, ON**	☐ **Oakville, ON**	☐ **St. John's, NL**	☐ **Halifax, NS**	☐ **Cambridge, 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.

Affliate Code:________________________