CANNABINOID
MEDICAL CLINIC

Consult Request Form

Fax Form to: 416-482-3535

Refer to next available physician: Y / N

Physician of choice: ________________

Date: ______ ______ ______

Patient Name: ____ DOB: ______ ______ ______
First Middle Last Month / Day / Year

Phone Number: (Day_________________________ (Evening)___________________________

Address:____

OHIP:_______________________________ Email:____________________________________

Reason For Referral:

☐ Assess suitability for cannabinoid therapy ☐ Other ____________________________________

Diagnosis:

☐ Chronic Pain ☐ Fibromyalgia ☐ Cancer ☐ Gastrointestinal ☐ PTSD
☐ Anxiety ☐ Sleep Disorder ☐ Arthritis ☐ Multiple Sclerosis
☐ Other ____

Current medication: ____

Medication Tried for Primary Condition: ____

Previous Cannabinoid Use: ☐ Nabilone ☐ Sativex ☐ Cannabis

Referring Physician:

	Stamp
______________________________________ Name (Print) ______________________________________ Signature ______________________________________ Billing # Phone: ______________________________ Fax: ______________________________ Address: ______________________________ ______________________________ Email: ______________________________	

Please send all pertinent medical records pertaining to main diagnosis including recent consultations with specialists and diagnostic imaging reports.