CANNABINOID MEDICAL CLINIC

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:

Are you a member of a FHO/FHN/FHT? (Ontario Physicians ONLY) ☐YES ☐ NO

Referring Physician: _____ Phone: _____ Fax: _____

Referring Physician Signature: _____ **Date:** _____

Billing# _____ **Prac.ID#** _____

Please Select a Clinic:

☐ Telemedicine

☐ Calgary, AB ☐ Edmonton, AB ☐ Winnipeg, MB ☐ Barrie, ON ☐ Burlington, ON ☐ Hamilton, ON
☐ Kingston, ON ☐ Ottawa, ON ☐ Stoney Creek, ON ☐ Toronto, ON ☐ St. John's, NL ☐ Halifax, NS
☐ Moncton, NB

Please attach any relevant medical history, all pertinent scans and imaging and any pertinent consults from other physicians or specialists.