IMAGINE HEALTH CENTRES

Physician Referral Form for Medical Cannabis Assessment

DATE OF REFERRAL: _____

Patient Information:

Name: _____ D.O.B.: _____dd-mmm-yyyy_____ PHN: _____

Address: _____street address_____ Phone: (H) _____ (C) _____

_____city and province_____ E-mail: _____REQUIRED_____

_____postal code_____

Referral:

☐ Assess suitability for Medical Cannabis

☐ Yes ☐ No Is the patient currently taking anti-coagulants?
☐ Yes ☐ No Is the patient breastfeeding, pregnant, or trying to become pregnant?
☐ Yes ☐ No Does the patient have a significant communicable disease? (i.e. HIV, Hepatitis, etc.)
☐ Yes ☐ No Does the patient have untreated substance abuse issues/addiction?

Systemic/Other:

☐ Chronic Pain (iatrogenic, operative, post traumatic)
☐ Immunological Condition _____PLEASE SPECIFY_____
☐ Inflammatory Polyarthropathy (RA, gout, other arthritis)
☐ Neurodegenerative Disease _____PLEASE SPECIFY_____
☐ Cancer _____PLEASE SPECIFY_____
☐ Neuropathic Pain
☐ Osteoarthritis
☐ Spondyloarthropathy
☐ Fibromylagia
☐ Other _____PLEASE SPECIFY_____

Has the patient been assess by a Pain Specialist, Neurologist, Rheumatologist, or Oncologist?

Mental Health:

☐ Anxiety/Depression ☐ PTSD ☐ Sleep Disorder ☐ Schizophrenia ☐ Psychosis

Has the patient been assessed by a Psychiatrist, GP/Psychotherapist, or Clinical Psychologist? ☐ YES ☐ NO

Medications Tried for Current Condition (please include current medications and dosages):

_____

Physician Information:

Referring Physician: _____PLEASE PRINT CLEARLY_____ **Referring Physician Signature: _____**

Tel: _____ **Fax: _____** **Prac ID: _____**

Please select a clinic: ☐ **Macleod Trail South**
4120, 15 Sunpark Plaza SE
Fax: 403 910 0449
Tel: 403 910 3990

☐ **Downtown Macleod Trail**
300, 6 Avenue SE
Fax: 403 775 9812
Tel: 403 775 9669

Please attach any relevant medical history/scans/consults from other physicians or specialists.