Cannabis Quest
Medical Clinic

Physician Referral Form

Phone: (416) 720-4322
Fax: (416) 352-5736
www.cannabisquestmedical.com

Name:_____ DOB:_____ Health Card#_____

Address:_____ City:_____ Postal Code:_____

Phone (H)_____ Cell:_____ Email:_____

Service Referral:

☐ Suitable for Medical Cannabis
☐ YES ☐ NO Is patient Pregnant, or trying to become pregnant?
☐ YES ☐ NO Is patient taking anti-coagulants?
☐ YES ☐ NO Does the patient have a significant communicable disease? (HIV, Hepatitis, etc.)
☐ YES ☐ NO Does Patient have an untreated substance addiction or abuse?

Mental Health:

☐ Anxiety/ Depression ☐ Focus Related (ADHD) ☐ PTSD ☐ Sleep disorder ☐ Other_____
☐ Any previous assessment by Psychiatrist, GP, Psychotherapist or Clinical Psychologist?

Systemic/Other:

☐ Chronic pain: operative, post traumatic, iatrogenic
☐ Inflammatory Polyarthropathy
☐ Neurodegenerative disease (specify)_____
☐ Immunological condition (specify)_____
☐ Assess ever by a Pain Specialist, Neurologist, Rheumatologist or Oncologist
☐ Osteoarthritis
☐ Cancer (specify)_____
☐ Spondyloarthropathy
☐ Fibromyalgia
☐ Neuropatic Pain
☐ Other:_____

Any current Medications:

_____

Any Medications tired for condition:

_____

Referring Physician Designatin; ☐ FRCPSC ☐ FRCPC ☐ CCFP ☐ Other:_____

Referring Physician/Nurse Practitioner Signature:_____ Date:_____

Phone:_____ Fax:_____ Billing#_____

NOTE: Please attach any relevant medical history.