Indra Cooper
Tel: 905-860-0866 I Fax: 866-580-8965
info@caledonclinic.ca

Patient Referral Form for Cannabis Treatment

Patient Information: (Patient must be 25 years of age or older)
First name: ________________________
Last Name: ________________________

Date of Birth: ________________________

Health Card Number: ________________________
Version Code: ________________________
☐No Version Code

Patient Phone Number: ________________________

Patient Email address: ________________________

Reason for Referral: ____
☐ Chronic Pain
☐ Cancer Supportive Care
☐ Sleep Disturbance
☐ Mood Disorder

Urgent referral:
☐Yes ☐No
☐ Cancer Supportive Care
Other (Please Specify): ________________________

Patient's Medical/Psychiatric History:
☐ Copy of Cumulative Patient Profile (CPP) attached.
☐ Relevant Investigations and Consultations attached.
☐ Medication History attached.

Medications tried and not tolerated or not effective:
☐Opioids ☐SNRI ☐SSRI ☐NSAID ☐Gabapentinoid ☐Medical Cannabis

Cardiovascular Risk:
☐ my patient has an elevated cardiac risk
☐ unsatisfactory control of hypertension
☐ direct oral anticoagulant use
☐ vitamin K antagonist (warfarin)
☐ antiplatelet/antiaggregant

Does your patient have current or past history of:
☐ Alcohol use disorder
☐ Substance use disorder

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Social History:
☐ Employed ☐ Unemployed ☐ WSIB patient ☐ ODSP ☐Other Source of Income: ____________________________

Health Care Provider Information:
Referring MD/NP: ______________________________________
Billing number: ______________________________________
Address: ______________________________________
____
Phone: ______________________________________
Fax: ______________________________________

Please fax the completed form along with CPP and relevant reports to Caledon Clinic: 1 (866) 580-8965

Please explain to your patient: Caledon clinic will contact the patient by phone to arrange the appointment.

For Referring physician:
Please review and acknowledge; I confirm that I am the patient's physician and will be involved in this patient's care, providing ongoing care leading up to, during, and after this patient receives treatment at Caledon Clinic.
☐ I Confirm

X ____

Signature

____
Print Name

____
Date