7600 Weston Road, Unit 55, Woodbridge, ON, L4L 8B7
Phone: (289) 371-3500 • Fax: (289) 371-3399

90 Resolution Drive, Unit 2, Brampton, ON, L6W 0A7
Phone: (416) 883-3877 • Fax 1 (855) 320-2591

Medical Marijuana Therapy Assessment Referral Form

Patient name: _____

Patient address: _____

Date of birth: _____

_____

Health card #: _____

Home/cell phone: _____ /_____

Patient Enrollment Model Physicians - Check this Box ☐ for Consult by Specialist.

Patients with the following conditions and or symptoms may be referred for assessment:

- ☐ Nausea and vomiting (chemotherapy and non-chemotherapy associated)
- ☐ Wasting syndrome and loss of appetite in AIDS and cancer patients (stimulate appetite and produce weight gain)
- ☐ Anorexia nervosa
- ☐ Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
- ☐ Epilepsy and seizures
- ☐ Acute pain (acute pain or post-operative pain)
- ☐ Chronic pain (neuropathic pain or chronic non-cancer pain)
- ☐ Cancer pain
- ☐ Headache and migraine
- ☐ Musculoskeletal disorders (osteoarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis)
- ☐ Movement disorders (dystonia, Huntington's and Parkinson's diseases, Tourette's syndrome)
- ☐ Glaucoma
- ☐ Psychiatric disorders, **except schizophrenia** (anxiety and depression, sleep disorders, post-traumatic stress disorders, alcohol and opioid withdrawal symptoms)
- ☐ Alzheimer's disease and dementia
- ☐ Inflammatory skin diseases
- ☐ Gastrointestinal system disorders (irritable bowel syndrome, inflammatory bowel diseases, diseases of the liver, metabolic syndrome, obesity, diabetes, diseases of the pancreas)

*** Please attach all relevant imaging, blood work and or consults. ***

Reason for Referral (required):

_____

_____

_____

Name of Referring MD: _____ **Signature of referring MD:** _____

Referring MD billing #: _____ **Date of Referral:** _____

Our office will contact the patient to make an appointment date.