Medical Cannabis Referral Form

Phone: (780) 705 - 8400 ext. 2
Fax: +1 (855) 710 - 7863

Patient Name: ______________________ **Referral Date:** ______________

PHN: ______________ **Phone #:** ______________ **Alternate #** ______________

DOB: ______________ **Address:** ______________________

Patients with the following conditions or symptoms may be referred for assessment and trial of Medical Cannabis:

- ○ Nausea & vomiting (cancer treatment)
- ○ Wasting syndrome and loss of appetite in AIDS and cancer patients (stimulate appetite and produce weight gain)
- ○ Anorexia nervosa (ongoing psych assistance required)
- ○ Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
- ○ Epilepsy or seizures
- ○ Acute pain (or post-operative pain)
- ○ Chronic Pain (neuropathic or chronic non-cancer pain)
- ○ Cancer Pain
- Headaches, migraines or clusters
- ○ Musculoskeletal disorders (osteoarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis)
- ○ Movement disorders (dystonia, Huntington's and Parkinson's diseases, Tourette's syndrome)
- ○ Glaucoma (ophthalmologist referral only)
- ○ Anxiety and Depression
- ○ Psychiatric disorders, except schizophrenia (anxiety and depression, sleep disorders, post-traumatic stress disorders, alcohol and opioid withdrawal symptoms)
- ○ Gastrointestinal system disorders (irritable bowel syndrome, inflammatory bowel diseases, diseases of the liver, metabolic syndrome, obesity, diabetes, diseases of the pancreas)

Patients under 25yrs of age will only be seen when they have already had a psychiatric assessment done or are referred by a specialist, other than for the following conditions:

- ○ Palliative Conditions
- ○ Movement Disorders
- ○ Cancer Treatments
- ○ Neuromuscular Disorder
- ○ Epilepsy

Reason for Referral (required): ______________________

Name of Referring Dr. ______________________ **Prac ID:** ______________

Name of Clinic: ______________________

Phone #: ______________ **Fax #:** ______________

Physician Signature: ______________

Our office will contact your patient when an appointment has been made.
Please attach all relevant imaging, blood work,consults and most current medication list.

Thank you,
Dx Cannabis Team