SANTÉ CANNABIS

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PATIENT SELF-REFERRAL FORM

PLEASE INDICATE THE CLOSEST REGION OR CITY TO YOU:

☐ Montreal ☐ South-Shore ☐ West Island ☐ Laval/Laurentians ☐ Quebec ☐ Sherbrooke ☐ Other: _____

PERSONAL INFORMATION

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Date of Birth: _____ **RAMQ:** _____ **Date:** _____

Phone: ( ) _____ **Email:** _____

Name of family doctor or specialist: _____

Name of clinic or hospital centre: _____

Primary diagnosis: _____

Reason for consultation: _____

Please describe the symptoms for which you are seeking medical cannabis treatment: _____

Have you been to a psychiatrist/psychologist? ☐ No ☐ Currently ☐ Previously **Name:** _____

Have you tried medications to relieve your symptoms? ☐ No ☐ Currently ☐ Previously

Do you use cannabis or cannabis products? ☐ No ☐ Currently ☐ Previously **and indicate:** ☐ Medically ☐ Recreationally

If yes, please provide details: _____

PLEASE INDICATE IF YOU HAVE A HISTORY OF:

☐ None

☐ **Heart problem** (cardiologist report mandatory)

☐ **High blood pressure**

☐ **Schizophrenia or episode of psychosis** (psychiatrist report mandatory)

☐ **Substance use disorder** (alcohol, drugs)

***Please attach all documents relevant to your medical condition to assess your file:**

☐ **Summary of medical file or recent notes**

☐ **List of medications** (last 3 years)

☐ **Medical imagery report** (if applicable)

☐ **Psychiatric report** (if applicable)

ATTESTATION

By signing below, I confirm that the information provided are true and accurate.

First Name: _____ **Last Name:** _____

Signature: _____ **Date:** DD / MM / YYYY