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 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:** ____________