SANTÉ CANNABIS

Montréal
Pointe-Claire
Sherbrooke

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REFERRAL FOR CONSULTATION

☐ **URGENT**

CLOSEST CLINIC: ☐ Montréal ☐ Pointe-Claire ☐ Sherbrooke ☐ Lives more than 100km away from listed clinics

PATIENT INFORMATION

First Name: _____ **RAMQ Number:** _____

Last Name: _____ **Expiration Date:** _____

Pronoun: ☐ He ☐ She ☐ They ☐ Other: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

City: _____ **Email:** _____

Province: _____ **Postal Code:** _____ **Caregiver's Name:** _____

GENERAL MEDICAL INFORMATION (MANDATORY)

Reason(s) for referral:

Primary Diagnosis:

Secondary Diagnoses:

PERTINENT MEDICAL INFORMATION (MANDATORY) PLEASE CHECK ALL THAT APPLY:

- ☐ **Schizophrenia, psychosis, or bipolar 1 disorder** — *if yes,* ☐ Currently ☐ Previously
- ☐ **Pregnant, breastfeeding, or planning to get pregnant**
- ☐ **Immunotherapy** — *if yes,* ☐ In the last 6 months ☐ Currently ☐ Upcoming
- ☐ **Anticoagulants** — *if yes, specify:*
- ☐ **Severe renal dysfunction**
- ☐ **Severe liver dysfunction** — *if yes, specify:*
- ☐ **Uncontrolled high blood pressure**
- ☐ **Cardiovascular diseases** ☐ Unstable ☐ Stable — *if yes,* ☐ Arrythmia ☐ Atrial Fibrillation ☐ CVA ☐ TIA ☐ Other(s), *specify:*
- ☐ **Substance use disorder** (alcohol, drugs) — *if yes,* ☐ Currently ☐ Previously
  Specify:

*** If yes to any of the above, please attach consultation notes and/or pertinent medical reports**

HEALTHCARE PROFESSIONAL INFORMATION (STAMP, IF AVAILABLE)

First Name: _____ **Licence Number:** _____

Last Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Email:** _____

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

Signature: _____ **Date:** _____

☐ **Interested in information about our Prescriber Training Program**
*** Check our website for more information: santecannabis.ca**