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:** 2022-08-06

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:** 2022-08-06

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