SANTÉ CANNABIS

Montréal
Sherbrooke

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REFERRAL FOR CONSULTATION

☐ **URGENT**

CLOSEST CLINIC: ☐ Montréal ☐ 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:

PLEASE INDICATE ☐ **Pharmaceutical treatments have been tried** ☐ **or refused by the patient**

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

☐ **Schizophrenia, psychosis, or bipolar 1 disorder**
if yes, ☐ Currently ☐ Previously

☐ **Immunotherapy**
if yes, ☐ In the last 6 months ☐ Currently ☐ Upcoming

☐ **Pregnant, breastfeeding, or planning to get pregnant**

☐ **Anticoagulants:**
if yes, specify: _____

☐ **Severe renal dysfunction**
if yes, specify: _____

☐ **Severe liver dysfunction**
if yes, specify: _____

☐ **Uncontrolled high blood pressure**

☐ **Cardiovascular diseases**
if yes, ☐ Arrythmia ☐ Atrial Fibrillation ☐ CVA ☐ TIA
☐ Other(s), *specify:* _____
☐ Unstable ☐ Stable

☐ **Substance use disorder (alcohol, drugs)**
Specify: _____
if yes, ☐ Currently ☐ Previously

*** 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**