SANTÉ CANNABIS

Montréal
Sherbrooke

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PATIENT SELF-REFERRAL FORM

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:** _____

RELEVANT MEDICAL INFORMATION

Main medical diagnosis: _____

Main symptom/reason for consultation: _____

Other diagnoses and health problems: _____

Recent stay at the hospital (last 5 years): _____

RELEVANT MEDICAL INFORMATION CHECK ALL THAT APPLIES TO YOU:

- ☐ **Do you have schizophrenia or a history of psychosis?**
- ☐ **Do you have type 1 bipolar disorder?**
- ☐ **Are you pregnant, nursing or planning to get pregnant soon?**
- ☐ **Did you have cancer immunotherapy treatments in the past 6 months or will you have one in upcoming months?**
- ☐ **Are you taking blood thinning medication?**
- ☐ **Do you have renal problems?**
- ☐ **Do you have liver problems?**
- ☐ **Do you have a heart disease?**
- ☐ **Do you have high blood pressure?**
- ☐ **Do you have a current or past history of drug dependence** (i.e.: alcohol, drugs)?

HISTORY OF CANNABIS USE

☐ **Never tried before** ☐ **Medical or self-attempted treatments** ☐ **Recreational** ☐ **Medical and Recreational**

MEDICAL DOCUMENTS TO ADD TO YOUR REFERRAL *Please attach all documents relevant to your health condition to your file

An incomplete file can delay the processing of your referral.

- **Medical summary, consultation notes**
- **Medication lists** (active and last 3 years)
- **Medical imagery/radiology** (if applicable)
- **Psychologic/psychiatric report** (if applicable)

ATTESTATION

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

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

Signature: _____ **Date:** _____