

# REFERRAL FOR CONSULTATION

**URGENT**

**CLOSEST CLINIC:** Montréal Sherbrooke Lives more than 100km away from listed clinics

## PATIENT INFORMATION

<b>First Name:</b> _____	<b>RAMQ Number:</b> _____
<b>Last Name:</b> _____	<b>Expiration Date:</b> _____
<b>Pronoun:</b> He She They Other: _____	<b>Date of Birth:</b> _____
<b>Address:</b> _____	<b>Phone:</b> _____
<b>City:</b> _____	<b>Email:</b> _____
<b>Province:</b> _____ <b>Postal Code:</b> _____	<b>Caregiver's Name:</b> _____

## 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:

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Schizophrenia, psychosis, or bipolar 1 disorder</b><br>if yes, <input type="checkbox"/> Currently <input type="checkbox"/> Previously           | <input type="checkbox"/> <b>Uncontrolled high blood pressure</b>   |
| <input type="checkbox"/> <b>Immunotherapy</b><br>if yes, <input type="checkbox"/> In the last 6 months <input type="checkbox"/> Currently <input type="checkbox"/> Upcoming | <input type="checkbox"/> <b>Cardiovascular diseases</b><br>if yes, <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> CVA <input type="checkbox"/> TIA<br><input type="checkbox"/> Other(s), specify: _____ |
| <input type="checkbox"/> <b>Pregnant, breastfeeding, or planning to get pregnant</b>  | <input type="checkbox"/> Unstable <input type="checkbox"/> Stable  |
| <input type="checkbox"/> <b>Anticoagulants:</b><br>if yes, specify: _____   | <input type="checkbox"/> <b>Substance use disorder (alcohol, drugs)</b><br>Specify: _____  |
| <input type="checkbox"/> <b>Severe renal dysfunction</b><br>if yes, specify: _____  | if yes, <input type="checkbox"/> Currently <input type="checkbox"/> Previously   |
| <input type="checkbox"/> <b>Severe liver dysfunction</b><br>if yes, specify: _____  |  |

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

## HISTORY OF CANNABIS USE

Never tried before      Medical or self-attempted treatments      Recreational      Medical with authorization

## HEALTHCARE PROFESSIONAL INFORMATION (STAMP, IF AVAILABLE)

<b>First Name:</b> _____	<b>Licence Number:</b> _____
<b>Last Name:</b> _____	<b>Phone:</b> _____ <b>Fax:</b> _____
<b>Address:</b> _____	<b>Email:</b> _____
<b>City:</b> _____ <b>Province:</b> _____	<b>Postal Code:</b> _____
<b>Signature:</b> _____	<b>Date:</b> _____

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