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Medical Cannabis Therapy Assessment Referral Form

Patient name: _____ Patient address: _____

Date of birth: _____

Health card #: _____ Home/cell phone: _____ / _____

Patient Enrollment Model Physicians - Check this Box for Consult by Specialist.

Patients with the following conditions and or symptoms may be referred for assessment:

- Nausea and vomiting (chemotherapy and non-chemotherapy associated)
- Wasting syndrome and loss of appetite in AIDS and cancer patients (stimulate appetite and produce weight gain)
- Anorexia nervosa
- Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
- Epilepsy and seizures
- Acute pain (acute pain or post-operative pain)
- Chronic pain (neuropathic pain or chronic non-cancer pain)
- Cancer pain
- Headache and migraine
- Musculoskeletal disorders (osteoarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis)
- Movement disorders (dystonia, Huntington's and Parkinson's diseases, Tourette's syndrome)
- Glaucoma
- Psychiatric disorders, **except schizophrenia** (anxiety and depression, sleep disorders, post-traumatic stress disorders, alcohol and opioid withdrawal symptoms)
- Alzheimer's disease and dementia
- Inflammatory skin diseases
- Gastrointestinal system disorders (irritable bowel syndrome, inflammatory bowel diseases, diseases of the liver, metabolic syndrome, obesity, diabetes, diseases of the pancreas)

***** Please attach all relevant imaging, blood work and or consults. *****

Reason for Referral (required):

Name of Referring MD: _____ Signature of referring MD: _____

Referring MD billing #: _____ Date of Referral: _____

Our office will contact the patient to make an appointment date.