REFERRED BY
CANNA RELIEF CONSULTING
MISSISSAUGA, ONTARIO
P:905-286-4420 E: info@cannarelief420.ca

FAX TO 1 866 837 7291

MEDICAL CANNABIS ASSESSMENT:
PATIENT REFERRAL FORM

SOLACE HEALTH
NETWORK

PATIENT INFO

Gender: Male ☐ Female ☐ Other ☐

First Name: _____ Last Name: _____

Date of Birth: (dd/mm/yy) _____ Email: _____

Phone: _____ Can a voice message be left at this number? Yes ☐ No ☐

Address: _____ Suite No.: _____

City: _____ Province: _____ Postal Code: _____

Health Card # (with Version Code) _____ Caregiver Name: (if applicable) _____

REASON FOR REFERRAL & DIAGNOSIS

☐ Anxiety
☐ Arthritis
☐ Cancer
☐ Chronic Pain (post traumatic, operative, iatrogenic)
☐ Colitis/Crohn's
☐ Depression
☐ Fibromyalgia
☐ Migraines
☐ Multiple Sclerosis
☐ Palliative Care
☐ PTSD
☐ Seizures
☐ Sleep Disorder
☐ Other _____

BRIEF HISTORY FOR REFERRING CONDITION (I.E. PREVIOUS MEDS/INTERVENTIONS TRIED)

POTENTIAL CONTRAINDICATIONS

☐ Unstable Heart Disease
☐ Breastfeeding
☐ Pregnant or Trying to Get Pregnant
☐ Psychosis or Strong Family History of Psychosis
☐ Untreated substance/abuse addiction

REFERRING PHYSICIAN INFORMATION

FRCPSC ☐ FRCPC ☐ CCFP ☐ Other ☐ NP ☐

First Name: _____ Last Name: _____

Billing Number: _____ Phone: _____ Fax: _____

Address: _____ Email: _____

Physician's Signature _____ Date: (dd/mm/yy) _____

Please include all relevant medical documentation with referral form, including investigations, consult reports, and medication lists.

T 1 866 837-7251 **F** 1 866 837-7291 **E** info@solacehealthnetwork.com PO Box 43125 Mississauga ON, L5B 4A7