CannaWay Clinic

A division of Priority Care Specialist Clinic Inc.

Excellence in Care

Specialist Consultation Referral

PATIENT INFORMATION

Last Name _____

First Name _____

Birth Date (Y/M/D) _____ Gender _____

OHIP _____ Ver. Code _____

Email _____ Tel _____

Address _____

PHYSICIAN INFORMATION

Physician Name _____

Address _____

Tel _____ Fax _____

Billing # _____ Date _____

Physician Signature _____

REASON FOR CONSULTATION

Chronic Pain Syndrome

- ○ Arthritis
- ○ Inflammatory Polyarthropathy
- ○ Post Operative/Traumatic
- ○ Fibromyalgia
- ○ Neuropathic _____
- ○ Malignancy _____
- ○ Other _____

Mental Health

- ○ Anxiety/Depression
- ○ PTSD
- ○ Eating Disorder
- ○ ADHD
- ○ Other _____

_____

Neurologic

- ○ Cognitive Impairment
- ○ Seizure Disorder
- ○ Migraines/Headaches
- ○ Multiple Sclerosis
- ○ Parkinson's Disease
- ○ Other _____

Gastrointestinal

- ○ Crohn's Disease
- ○ Ulcerative Colitis
- ○ Irritable Bowel Syndrome
- ○ Other _____

_____

Other

- ○ Insomnia
- ○ Sleep Disordered Breathing
- ○ Appetite Stimulation
- ○ HIV/AIDS
- ○ Recreational User Consultation for Harm Prevention

Current Medications

_____

_____

_____

_____

_____

_____

_____

Currently taking Anticoagulants	○ Yes	○ No
Pregnancy or Family Planning	○ Yes	○ No
History of Substance Abuse/Addiction	○ Yes	○ No
History of Psychotic Illness	○ Yes	○ No

RELEVANT MEDICAL HISTORY – Please include **Cumulative Patient Profile (CPP)**, all relevant test results and consultation notes.

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