PEDIACTRIC CONSULT REFERRAL

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Is the patient rostered with a FHT or FHO? Y ◯ N ◯

Assign to next available Physician? Y ◯ N ◯

Referral for Dr. _____

Apollo Cannabis Clinics is a constantly growing community of academic physicians and researchers working to improve the lives of patients using medical cannabis.

Patient's Name: _____ DOB: _____ (DD/MM/YYYY) Date: _____

Patient's Address: _____ E-mail: _____

Phone: _____ Cell: _____ Patient's OHIP #: _____

Caregiver Information (If Applicable):

Caregiver's Name: _____ Phone: _____

E-mail: _____ Relationship to Patient: _____

Signature: _____ Date: _____ (DD/MM/YYYY)

Reason for Assessment ☐ Autism ☐ Epilepsy ☐ ADHD ☐ Anxiety ☐ Cancer ☐ Pain ☐ Other

Primary Diagnosis

Current Medical Conditions (Please provide a copy of medical records, including consults and prior treatments)

☐ History of Psychosis

List of current medication and allergies (Including dosage, duration of treatment)

List of medication that has been tried for the primary pain condition

REFERRING PHYSICIAN

_____ Referring physician's name (print)

_____ Referring physician's signature

_____ OHIP Billing #

Referring physician's direct phone: _____ Fax: _____

Address: _____ E-mail: _____

*If patient's OHIP number, or physician's billing number is not provided, patient will not be booked