HARVEST MEDICINE

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MEDICAL CANNABIS REFERRAL FORM

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Date:
Referral Dr. Name:
Phone #:
Fax #:
Practitioner ID#:

Previous Cannabinoid Use

- ☐ Nabilone
- ☐ Sativex
- ☐ Medical Cannabis
- ☐ Other:_____

Medications

- ☐ Warfarin
- ☐ Heparin
- ☐ Plavix/Dabigatran
- ☐ Other:_____

Patient Information:

LABEL HERE
PATIENT NAME / DOB
ALBERTA HEALTH #
ADDRESS / CONTACT / EMAIL

Primary Diagnosis + Physician Comments:

Please attach pertinent medical records.

Indications / Contraindications / Cautions

Indications

- ☐ Alzheimer's
- ☐ Anorexia / Eating Disorders
- ☐ Anxiety
- ☐ Arthritis (OA, RA, PA)
- ☐ Chemotherapy / Radiation Side-effects
- ☐ Chronic Neuropathic Pain (DM, Trigeminal)
- ☐ Chronic Pelvic Pain
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gastrointestinal - Irritable Bowel Syndrome
- ☐ Glaucoma
- ☐ HIV/AIDS Wasting Syndrome
- ☐ Inflammatory Skin Disease
- ☐ Insomnia / Sleep Disorders
- ☐ Migraines
- ☐ Movement Disorders
- ☐ Multiple Sclerosis
- ☐ Muscular Spasticity
- ☐ Musculoskeletal Disorders
- ☐ Myofascial Pain Syndrome
- ☐ Nausea
- ☐ Palliative Care
- ☐ Parkinson's
- ☐ Post-Concussion Headaches/CTE
- ☐ PTSD
- ☐ Sciatica/Radicular Pain

Contraindications / Cautions

- ☐ Age < 18 Years Old
- ☐ Breastfeeding
- ☐ Known Substance Abuse
- ☐ Occupational Hazard (Heavy Machinery, Driving)
- ☐ Pregnant
- ☐ Schizophrenia / Bipolar
- ☐ Unstable CVS / Resp Disease

*Please note: your patients will be contacted directly by the Harvest Medicine team.