



MEDICAL CANNABIS REFERRAL FORM

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|----------------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> North | <input type="checkbox"/> AB | <input type="checkbox"/> NS | <input type="checkbox"/> QC |
| <input type="checkbox"/> South | <input type="checkbox"/> BC | <input type="checkbox"/> NT | <input type="checkbox"/> SK |
| <input type="checkbox"/> East | <input type="checkbox"/> MB | <input type="checkbox"/> NU | <input type="checkbox"/> YT |
| <input type="checkbox"/> West | <input type="checkbox"/> NB | <input type="checkbox"/> ON | |
| <input type="checkbox"/> Central | <input type="checkbox"/> NL | <input type="checkbox"/> PE | |

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