HARVEST MEDICINE

Harvest Medicine Inc.
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MEDICAL CANNABIS REFERRAL FORM

☐ North	☐ AB	☐ NS	☐ QS
☐ South	☐ BC	☐ NT	☐ SK
☐ East	☐ MB	☐ NU	☐ YT
☐ West	☐ NB	☐ ON	
☐ Central	☐ NL	☐ 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:

Patient Name: _____
Date of Birth: _____
Provincial Health#: _____
Address: _____
Phone: _____
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
- ☐ 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.