TORONTO POLY CLINIC
Multidisciplinary Pain Management
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Accepting New Patients

Medical Cannabis Referral Program Form

To help avoid delays, please fill out the complete form to ensure prompt attention. We will contact the patient directly.

Patient Info

*Health Card _____ VC _____ *DOB _____

*Name _____ *Cell _____ Alt.Tel. _____

*Address _____ *City _____ ON *PC _____

Does the patient have 3rd party coverage? If yes, please provide insurance provider _____

Is this patient a New Patient ☐ Re-referral ☐

Physician Info

*CPSO# _____ *Billing# _____ Specialty: _____

*Dr. _____ *Tel. _____ *Fax _____

*Address _____ *City _____ ON *PC _____

Are you the patient's Family Physician or Most Responsible Physician (MRP)? Yes ☐ No ☐

Do you belong to a: FHO ☐ FHT ☐ FHG ☐ CCM ☐ OTHER: _____

History

History of Drug/Alcohol abuse or addiction? Yes ☐ No ☐

Is the patient 25 and older? Yes ☐ No ☐

Is the patient schizophrenic? Yes ☐ No ☐

Referred For (Check One)

- ☐ Pain Management
- ☐ Post MVA Rehabilitation
- ☐ Independent Assessment
- ☐ Treatment u/ Floroscopy
- ☐ W.S.I.B
- ☐ General Referral

1. Pain History: _____

3. Investigations and Consultations: _____

2. Physical Examination Findings: _____

4. Previous Pain Related Procedures: _____

Please provide us will all pertinent medical records including MRI, CT, X-RAY, NCS/EMG, Bone Scan or Lab (CBC, INR, PTT, CR) reports, relevant consultations or prior treatment.

Toronto Poly Clinic will not assume sole responsibility for prescriptions

As the most responsible physician, by signing the below, I agree to continue the patient's prescription and primary care once the patient is stable and under the care of TPC.

WE CAN PROVIDE EARLY APPOINTMENTS TO YOUR CLIENTS

_____ Physician Signature

_____ Date