



Headquarters:
 240 Duncan Mill Road - Suite
 201 Toronto, Ontario, M3B 3S6
 P: 416 840 5991 / F: 647 729 4766
 TOLL FREE: 877 560 9195

CONSULT REFERRAL

Fax form to: 647.729.4766 (Toronto,ON)

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: _____ Date: _____
DD/MM/YYYY

Patient's Address: _____ E-mail: _____

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

Reason for assessment	<input type="checkbox"/> Pain	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep	<input type="checkbox"/> MS	<input type="checkbox"/> Cancer	<input type="checkbox"/> PTSD	<input type="checkbox"/> Other
Primary Diagnosis							
Current Medical Conditions <small>(Please provide a copy of medical records, including consults and prior treatments)</small>							
<input type="checkbox"/> History of Psychosis							
List of current medication and allergies <small>(Including dosage, duration of treatment)</small>							
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**