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Apollo Cannabis Clinics is a constantly growing community of academic physicians and researchers working to improve the lives of patients using medical cannabis.

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. _____

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 Provider #

Referring physician's direct phone: _____ Fax: _____

Address: _____ E-mail: _____