apollo™ Cannabis Clinics

Headquarters:
240 Duncan Mill Road - Suite 201
Toronto, Ontario, M3B 3S6
P: 416 840 5991 Ext. 208 / F: 647 729 4766
Toll Free Phone #: 877 560 9195
Toll Free Fax #: 866 821 0777

Fax complete package toll free to
1 866 821 0777
or email: homecare@apolloresearch.ca
Patient needs help with video set up:
Y ◯ N ◯

Patient Referral

To be completed to self-refer OR complete bottom section if referred by a Healthcare Professional.

Patient Information:

Name: _____ DOB: _____ (MM/DD/YYYY) Gender: _____

Address: _____ Phone: _____

Name of Residence: _____ Unit #: _____ E-mail: _____

Health Card #: _____ Health Card Expiry: _____ (MM/DD/YYYY)

Do you have an open Motor Vehicle Accident Claim? Y ◯ N ◯ | Have you ever used Cannabis? Y ◯ N ◯

Are you a veteran? Y ◯ N ◯ If yes, K# _____ Appointment time preference: ☐ Daytime ☐ Evening ☐ Weekends

Reason for Assessment: ☐ Pain ☐ Anxiety ☐ Sleep ☐ BPSD ☐ Depression ☐ Cancer ☐ Fibromyalgia ☐ PTSD ☐ Other

Current medical conditions (please provide a copy of medical records, including consults & prior treatments)

☐ History of Bipolar
☐ History of Schizophrenia
☐ History of Psychosis

This section is to be completed by your Healthcare Professional if you are being referred.

REFERRING HEALTHCARE PROFESSIONAL

_____ Healthcare Professional Name (Print)

_____ Healthcare Professional Signature

_____ MM/DD/YYYY

Healthcare Professional phone: _____ Fax: _____

Address: _____ E-mail: _____

Designation: _____ Billing #: _____

Headquarters:
240 Duncan Mill Road - Suite 201
Toronto, Ontario, M3B 3S6
P: 416 840 5991 Ext. 208 / F: 647 729 4766
Toll Free Phone #: 877 560 9195
Toll Free Fax #: 866 821 0777

Patient Referral - Page 2

Pursuant to Personal Health Information Protection Act, 2004 (PHIPA)

I _____ (Patient / Power of Attorney) confirm that I have given _____ (Caregiver(s))

full authorization to share, work & communicate with Apollo Applied Research Inc. and Apollo Cannabis Clinics to collect my medical health information & documentation regarding my medical condition(s). My caregiver may act as my representative and decision maker for attending and making appointments with my physician at the Apollo Cannabis Clinic, if I am unable to attend due to my medical condition. A true copy of the power of attorney is attached hereto.

To be completed in full by patient (or person authorized under PHIPA to consent on behalf of an individual to disclose personal health information about the patient).

Patient Signature: _____ Date: _____ MM/DD/YYYY

Power of Attorney:

Given Name: _____ Surname: _____ DOB: _____ MM/DD/YYYY

Relationship: _____ Phone: _____ E-mail: _____

Signature: _____ Date: _____ MM/DD/YYYY Proof of POA attached: Yes ◯

Family Caregiver:

Caregivers Name: _____ Phone: _____

E-mail: _____ Relationship: _____

Signature: _____ Date: _____ MM/DD/YYYY

Continuing Care Home & Health Caregiver:

Name of Residence: _____ Phone: _____

Caregiver Name: _____ Job Title: _____

Address: _____ Fax: _____

E-mail: _____ Is this an OTN facility? Y ◯ N ◯

Signature: _____ Date: _____ MM/DD/YYYY