



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

Fax complete package to:  
1 866-821-0777 (Toll Free)  
Is the patient rostered with FHT or FHO?  
Y  N

Refer to: \_\_\_\_\_

## REFERRAL FORM

### PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
MM/DD/YYYY

Patient's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Health Card Expiry: \_\_\_\_\_  
MM/DD/YYYY

E-mail: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

Is the patient a veteran? Y  N

Caregiver Name (If Applicable): \_\_\_\_\_

Caregiver Phone #: \_\_\_\_\_ Caregiver E-mail: \_\_\_\_\_

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

Current medical conditions (please provide a copy of medical records, including consults + prior treatments and list any current medication)

History of Bipolar  
 History of Schizophrenia  
 History of Psychosis

### REFERRING HEALTHCARE PROFESSIONAL

Healthcare Professional name (print) \_\_\_\_\_ Healthcare Professional signature \_\_\_\_\_ Billing # (If applicable) \_\_\_\_\_

Healthcare Professional phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_