SANTÉ CANNABIS

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REFERRAL FOR PSYCHEDELIC-ASSISTED THERAPY PROGRAM

CLOSEST CLINIC: ☐ Montréal ☐ Sherbrooke ☐ Lives more than 100km away from listed clinics ☐ **URGENT**

PATIENT INFORMATION

First Name: _____ **RAMQ #:** _____ **Expiry:** mm/yy

Last Name: _____ **Date of Birth:** _____

Pronoun: ☐ He ☐ She ☐ They ☐ Other: _____ **Phone:** _____

Address: _____ **Email:** _____

City: _____ **Support Person's Name:** _____

Province: _____ **Postal Code:** _____ ☐ Patient is low-income and requires compassionate access program

GENERAL MEDICAL INFORMATION (MANDATORY)

Reason(s) for referral: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

PLEASE INDICATE ☐ At least two pharmaceutical treatments have been tried ☐ Or refused by the patient

☐ **Patient has been assessed and/or** ☐ Followed by a ☐ Psychiatrist or ☐ Psychologist during during the period: mm/yy

☐ **Patient has been hospitalized for a mental health-related concern in the last five years** *If yes, specify:* _____

PERTINENT MEDICAL INFORMATION (MANDATORY) PLEASE CHECK ALL THAT APPLY:

☐ **Pregnant, breastfeeding, or planning to get pregnant**

☐ **Personal history of Schizophrenia, psychosis, or bipolar 1 disorder**
If yes, ☐ Currently ☐ Previously

☐ **Family history of schizophrenia or psychosis**

☐ **Severe renal dysfunction or liver dysfunction**
If yes, specify: _____

☐ **Uncontrolled high blood pressure**

☐ **Active cardiovascular diseases**
If yes, specify: _____

☐ **Substance use disorder** (alcohol, drugs)
If yes, specify: _____

☐ **Active suicide risk or recent suicidal ideation**

*** If yes to any of the above, please attach consultation notes and/or pertinent medical reports**

Cannabis: ☐ Never tried before ☐ Medical or self-attempted treatments ☐ Recreational ☐ Medical with authorization

Psychedelic Drugs: ☐ Never tried before ☐ Medical or self-attempted treatments ☐ Recreational ☐ Medical with authorization

If yes, specify: _____

HEALTHCARE PROFESSIONAL INFORMATION (STAMP, IF AVAILABLE)

Profession: _____ **Name:** _____

License #: _____ **Province:** _____

Signature: _____ **Date:** _____

Email: _____

The consultation took place at the business address:

STAMP

Address: _____

City: _____ Province: _____

Postal Code: _____

Phone: _____ Fax: _____

☐ **Interested in information about on medical cannabis or psychedelic-assisted therapy**
*** Provide email above and check our website for more information: santecannabis.ca**