SUMMERTREE
MEDICAL CLINIC

Consult Request Form
Fax: 416-964-2121
Phone: 416-913-7741

Date: ____________________________

Patient Name: ____ DOB: __________________________________

Phone Number (Day) __________________________________ (Evening) ____________________________________

Address ____

OHIP____

Email____

Cannabinoid Chronic Pain Clinic

Primary Diagnosis (check at least one)

- O Arthritis
- O Chronic Pain
- O Back Pain
- O Fibromyalgia
- O Peripheral Neuropathy
- O Multiple Sclerosis
- O Other

Secondary Diagnosis____

Medications ____

____

Past Medications and Treatment for Primary Condition ____

____

Please note that patients who require a translator or interpreter should make arrangements to bring a support worker.
Please forward pertinent imaging studies and recent assessments for primary diagnosis
Patient will be contacted with an appointment once all information has been received

Referring Physician

Name ____

Signature ____________________________________

Billing# _____________________________________

Phone _______________________________________

Fax ____

Address ______________________________________

____

Stamp