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