

Date: _____

Patient Name: _____ DOB: _____

Phone Number (Day) _____ (Evening) _____

Address _____

OHIP _____

Email _____

Cannabinoid Chronic Pain Clinic

Primary Diagnosis (check at least one)

- Arthritis Chronic Pain Back Pain Fibromyalgia Peripheral Neuropathy Multiple Sclerosis 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

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