– KAYA CLINICS –

289-499-2596 289-335-4696

Medical Cannabis Patient Referral Form

PATIENT INFORMATION

FIRST AND LAST NAME	PATIENT DATE OF BIRTH (DD/MM/YYYY)
ADDRESS	CONTACT PHONE NUMBER AND EMAIL
CITY, PROVINCE, POSTAL CODE	PATIENT GENDER MALE FEMALE OTHER
HEALTH CARD # (WITH VERSION CODE)	PATIENT CAREGIVER NAME (IF APPLICABLE)

REASON FOR REFERRAL

○ PALLIATIVE CARE	○ ANXIETY	○ DEPRESSION
○ SLEEP DISORDER	○ PTSD	○ CANCER
○ ANXIETY	○ CHRONIC PAIN	○ COLITIS/CROHN'S
○ SEIZURES	○ FIBROMYALGIA	○ ARTHRITIS
○ MULTIPLE SCLEROSIS	○ OTHER	○

OTHER:

POTENTIAL CONTRAINDICATIONS

○ UNSTABLE HEART DISEASE	○ BREASTFEEDING	○ PREGNANT OR TRYING TO GET PREGNANT
○ PSYCHOSIS OR STRONG FAMILY HISTORY OF PSYCHOSIS	○ UNTREATED SUBSTANCE ABUSE /ADDICTION	

REFERRING PHYSICIAN INFORMATION

DOCTORS FULL NAME: _____ ADDRESS: _____

PHONE NUMBER: _____ FAX NUNBER _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Send completed document to fax number: 289-335-4696

Email: kayaclinicsmedical@outlook.com