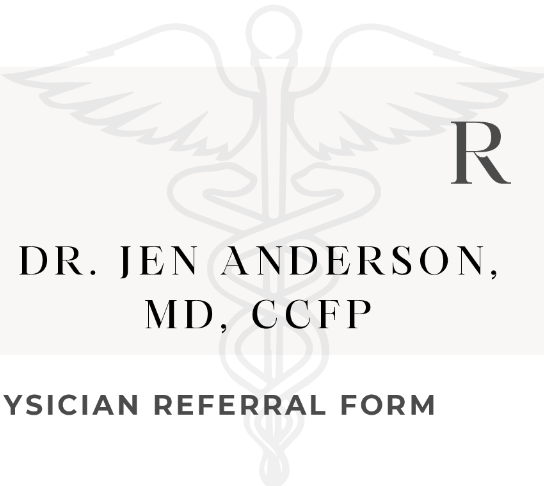

REFERRAL

DR. JEN ANDERSON,
MD, CCFP

CANNABINOID MEDICINE

ARA MEDICAL
10-1170 TAYLOR AVE
P:431-478-1550
F:431-478-1549

PHYSICIAN REFERRAL FORM

PATIENT INFORMATION

Name:_______________________________________

Address: _____________________________________

Email: _______________________________________

Phone #: _____________________________________

Referring physician:

____

Family physician:

____

Reason for referral:

____

____

Past medical history:

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REASON FOR REFERRAL

- ☐ Epilepsy
- ☐ Autism
- ☐ ADHD
- ☐ Harm reduction
- ☐ Chronic pain/opiod sparing
- ☐ Insomnia
- ☐ Cancer symptom management
- ☐ Tics/tourettes
- ☐ Anxiety/depression
- ☐ Skin condition ___________________
- ☐ Other_____________________________

☐ **Patient aware of referral?**

SUBSTANCE HISTORY

- ☐ daily alcohol_______/wk
- ☐ drug use_________________
- ☐ opiod dependance
- ☐ benzo dependence
- other: ___________________

Medications: (* especially blood thinners, chemo, antiepileptics)

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Allergies: ____