REFERRAL

CANNABINOID MEDICINE

DR. JEN ANDERSON
MD, CCFP

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

PEDIATRIC PATIENT REFERRAL

Name:_____
Address: _____
Email: _____
Phone #: _____

Referring physician:

_____

Family physician:

_____

Reason for referral:

_____

_____

Past Medical History

_____

_____

_____

_____

_____

_____

REASON FOR REFERRAL

- ☐ Epilepsy
- ☐ Autism
- ☐ ADHD
- ☐ Harm reduction
- ☐ Pain/opiod sparing
- ☐ Dermatology _____
- ☐ Cancer symptom management

- ☐ Tics/tourettes/movement d/o
- ☐ Anxiety/depression
- ☐ Other_____

OTHER INFO:

- ☐ Gtube
- ☐ palliative involved
- ☐ diet restrictions_____
- ☐ CFS/Caregiver_____

_____

Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____