Physician Referral Form

Phone: 1-866-336-ATMA (2862) | Fax: 1-833-329-ATMA (2862)

www.atmamedical.com *(downloadable referral)*

atma™
MEDICAL CLINIC

PATIENT INFORMATION

First Name:	Last Name:	☐ Male ☐ Female
Date of Birth:	Health Card #:	
Address:	City:	Postal Code:
Email *(required)*:	Phone:	☐ Home ☐ Cell

REASON FOR REFERRAL

☐ Medical Cannabinoid Assessment ☐ Continuation of Care for Cannabinoid Therapy ☐ Cannabis Education Only

DIAGNOSIS OR INDICATION FOR REFERRAL *(Check all that apply)*

☐ Chronic Pain (RA, OA, MS, MSK, Spasticity, Neuropathic) *(Non-cancer related pain)*
☐ Post-traumatic Pain *(MVA, etc.)*
☐ Inflammatory Polyarthropathy
☐ Cancer Pain
☐ Inflammatory Bowel Disease
☐ Multiple Sclerosis
☐ Spondyloarthropathy
☐ Fibromyalgia
☐ Other: ______________________

MENTAL HEALTH *(Check all that apply)*

☐ Anxiety ☐ PTSD ☐ Depression ☐ Sleep Disorder *(Insomnia)* ☐ Other: ______________

☐ This patient is currently being treated for mental health disease.

Dx: ______________________

☐ This patient is under the care of a licensed psychiatrist, psychologist, psychotherapist for mental health treatment.

Practitioner's Name: ______________________

DOES YOUR PATIENT HAVE ANY OF THE FOLLOWING? *(Check Yes or No)*

Question		
HIV, Hepatitis, Cirrhosis?	☐ YES	☐ NO
Glaucoma?	☐ YES	☐ NO
Schizophrenia / Bipolar Disorder / Psychosis?	☐ YES	☐ NO
Cardiovascular Disease / Respiratory Disease?	☐ YES	☐ NO
Prior or current illicit substance use / abuse (not including marijuana)?	☐ YES	☐ NO
Current Cannabis Use:	☐ YES	☐ NO
Prior or active opioid use?	☐ YES	☐ NO
Taking prescribed anticoagulants?	☐ YES	☐ NO
Occupational safety sensitive position (Heavy machinery, driving)?	☐ YES	☐ NO
Pregnant, breastfeeding or planning to become pregnant?	☐ YES	☐ NO
Previous Cannabis Use:	☐ YES	☐ NO

Current Cannabis Use: ☐ Nabilone ☐ Recreational Cannabis ☐ Sativex ☐ Medical Cannabis (herbal, oil, sprays, tinctures)

Previous Cannabis Use: ☐ Nabilone ☐ Recreational Cannabis ☐ Sativex ☐ Medical Cannabis (herbal, oil, sprays, tinctures)

PHYSICIAN INFORMATION

Physician Name:		Physician Signature:
Billing Number:	☐ Member of FHO / FHT	Date:
Practitioner Address:	City:	Postal Code:
Phone:	Fax:	

***Please attach additional CPP (Cumulative Patient Profile), diagnostic imaging, laboratory investigations and specialist consult notes** (Pain Specialist, Neurologist, Rheumatologist, Oncologist, Orthopedic Surgeon, Psychiatrist).

Documentation MUST be provided for patient visit.