



1188 Danforth Ave,  
Toronto Ontario M4J 1M3  
Phone: (416) 778-6777 Fax: (416) 778-7776  
Email: info@danforthwalkinclinic.com

## Medical Marijuana Therapy Assessment Referral Form

Patient name: \_\_\_\_\_ Patient address: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Health card #: \_\_\_\_\_ Home/cell phone: \_\_\_\_\_ / \_\_\_\_\_

**Patient Enrollment Model Physicians - Check this Box  for Consult by Specialist.**

**Patients with the following conditions and or symptoms may be referred for assessment:**

- Nausea and vomiting (chemotherapy and non-chemotherapy associated)
- Wasting syndrome and loss of appetite in AIDS and cancer patients (stimulate appetite and produce weight gain)
- Anorexia nervosa
- Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
- Epilepsy and seizures
- Acute pain (acute pain or post-operative pain)
- Chronic pain (neuropathic pain or chronic non-cancer pain)
- Cancer pain
- Headache and migraine
- Musculoskeletal disorders (osteoarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis)
- Movement disorders (dystonia, Huntington's and Parkinson's diseases, Tourette's syndrome)
- Glaucoma
- Psychiatric disorders, **except schizophrenia** (anxiety and depression, sleep disorders, post-traumatic stress disorders, alcohol and opioid withdrawal symptoms)
- Alzheimer's disease and dementia
- Inflammatory skin diseases
- Gastrointestinal system disorders (irritable bowel syndrome, inflammatory bowel diseases, diseases of the liver, metabolic syndrome, obesity, diabetes, diseases of the pancreas)

**\*\*\* Please attach all relevant imaging, blood work and or consults. \*\*\***

**Reason for Referral (required):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Referring MD: \_\_\_\_\_ Signature of referring MD: \_\_\_\_\_

Referring MD billing #: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Our office will contact the patient to make an appointment date.