tcn The Clinic Network

Tel: 1 (844) 262-826-2665 | Fax: 1 (844) 262-0947
Email: patientcare@theclinicnetwork.ca

Preferred Location: _____

Preferred TCN Physician: _____

Patient Referral Form

Physician Information

Referring MD: _____

Billing #: _____ License #: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Patient Information

Patient HCN: _____ Expiry Date: _____ DOB: _____

Patient Name: _____ Sex: _____ Gender: _____

Preferred Name: _____ Email: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Reason for Referral: _____

Medical/Psychiatric History: ☐ **ATTACHED** CV COPD Stroke/TIA OA/RA PVD Diabetes OSA
Mental Health Diagnosis ☐ Substance Abuse

Surgical/Trauma History: ☐ **ATTACHED** ☐ Was operated to treat pain ☐ Pain appeared after surgery/trauma

Medications: ☐ **ATTACHED** ☐ Anticoagulant/Antiaggregant ☐ Opioids ☐ Benzodiazepines
☐ Anticonvulsant/Antidepressant

Previous Treatments: **ATTACHED** Medications Injections Multidisciplinary PT Complimentary Medicine

Signature: _____ **Date:** _____

Please complete the above information and fax along with relevant reports to 1-844-262-0947, if you have any questions please reach out to our team at PH:1-844-262-0942 or via e-mail at patientcare@theclinicnetwork.ca

Please explain to your patient:

1. The clinic coordinator will contact your patient by phone to arrange the appointment.
2. Your patient will be asked to complete a pre-screen questionnaire Online or via telephone.
3. On the appointment day, patient must have an updated medication and allergies list.
4. We request all relevant reports to be sent before the scheduled visit.

For Family Physician: Please review and acknowledge.

After consultation with our physicians, patients are required to have follow up appointments throughout the duration of authorization to medical access to cannabis as per college guidelines.

I acknowledge that I have explained the reason and goals of this referral to my patient.

Signature: _____

Date: _____

According to college polices, the consultation request should include:

• Reason for referral • Urgency • Relevant medical history • Current medications • All relevant test and procedure results

Incomplete referrals will not be processed and will result in delay of patient care.