Sora Care

A virtual clinic dedicated to medical cannabis across Canada.

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Referral for Consultation

☐ **Urgent**

Patient Information

First Name: _____ **Healthcard #:** _____

Last Name: _____ **Expiration Date:** _____

Pronouns: ☐ He ☐ She ☐ They ☐ Other: **Date of Birth:** _____

Address: _____ **Phone:** _____

City: _____ **Email:** _____

Province: _____ **Postal Code:** _____ **Caregiver's Name:** _____

General Medical Information (Mandatory)

Reason(s) for referral:

Primary Diagnosis:

Secondary Diagnoses:

Please Indicate: ☐ **Pharmaceutical treatments have been tried** ☐ **Or refused by the patient**

Medical cannabis use: ☐ **Current** ☐ **Previous** ☐ **With authorization** ☐ **No authorization**

Risk Factors and Contraindications (Mandatory) Please check all that apply:

☐ **Pregnant, breastfeeding, or planning to get pregnant**
☐ **Schizophrenia, psychosis, or bipolar 1 disorder**
☐ **Immunotherapy**
if yes, ☐ **In the last 6 months** ☐ **Currently** ☐ **Upcoming**
☐ **Anticoagulants**
if yes, specify: _____
☐ **Severe renal dysfunction**
☐ **Severe liver dysfunction**

☐ **Cardiovascular diseases**
if yes, ☐ **Unstable** ☐ **Stable**
if yes, ☐ **Arrythmia** ☐ **Atrial Fibrillation** ☐ **CVA** ☐ **TIA**
☐ *Other(s), specify:* _____
☐ **Substance use disorder (alcohol, drugs)**
Specify: _____
if yes, ☐ **Currently** ☐ **Previously**
☐ **No risk factors or contraindications**

** If yes to any of the above, please attach consultation notes and/or pertinent medical reports*

Healthcare Practitioner Information (Stamp, if Available)

Name: _____

License #: _____ **Province:** _____

Is patient rostered in a capitation based model? ☐ Yes ☐ No

Signature: _____

Date: _____ **Email:** _____

Address: _____
City: _____ Province: _____
Postal Code: _____
Phone: _____ Fax: _____
STAMP

☐ **Please confirm if interested to learn about cannabis and medical cannabis training opportunities (Please add email above)**