Self Referral Form

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

www.atmamedical.com (downloadable referral)

atma™
MEDICAL CANNABINOID 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

- ☐ Chronic Pain *(Non-cancer related pain)*
- ☐ Post-traumatic Pain *(Motor Vehichle Accident, etc.)*
- ☐ Cancer Pain
- ☐ Ulcerative Colitis/Chrones Disease
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Sleep Disorder *(Insomnia)*

☐ Other: ______________________________

☐ **YES** ☐ **NO** Are you under the care of a licensed psychiatrist, psychologist, psychotherapist for mental health treatment?

PLEASE CHOOSE ONE

☐	Please obtain any necessary medical documents on my behalf from my family physician.
☐	I do not currently have a family physician but have had medical investigations for my condition. Please obtain any necessary medical documents on my behalf.
☐	I do not currently have a family physician or access to any previous medical records and agree to complete a thorough questionnaire with Atma Medical Clinic.

List below any investigations done over the last 2 years pertaining to your conditions:

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MEDICAL HISTORY	MEDICATIONS

← **Fill out consent on the reverse**

Consent To Release Information

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CONSENT TO RELEASE INFORMATION

I ______________________________ (Please print)

Authorize: ______________________________ (Please print the name of clinic, hospital or individual)

To disclose the following medical information to ***Atma Medical Clinic.***

I specifically authorize the release of the following:

- ☐ **Entire** health record as deemed necessary by Consulting physician *(required for all self referrals)* *(Including mental health assessments, diagnostic imaging, CPP, etc.)*
- ☐ Drug/Alcohol Abuse Treatment
- ☐ Psychiatric and Mental Illness Treatment
- ☐ Human Immunodeficiency Virus (H.I.V.) Antibody Test Results, and Treatment Information
- ☐ Registration Record
- ☐ History and Physical (Cumulative Patient Profile)
- ☐ Cardiac Reports (Including EKG & Echo Reports)
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Reports
- ☐ Visit/Encounter Notes
- ☐ Other: ______________________________

I expressly and voluntarily authorize disclosure of the above medical information. I further understand that I am not giving permission for any disclosure other than stated above. I understand that I may revoke this authorization at any time, except to the extent action has been taken. This release is effective for 30 days from the date signed, unless otherwise specified.

I understand that the parties in receipt of these records may not disclose the medical information obtained unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

______________________________ ______________________________
Signature of Patient | Date

______________________________ ______________________________
Health Card Number & Other Names Used | Date of Birth (YYYY/MM/DD)

______________________________ ______________________________
Parent, Guardian, or Legal Representative (State Your Relationship to the Patient) | Date

PLEASE FAX MEDICAL HEALTH RECORDS TO

1-833-329-ATMA (2862)