

# Referral Form

**Sethi Cannabis Clinic**

Ph: (905) 681-7676 Fax: (905) 681-7751  
 2349 Fairview St. Unit 215. Burlington, ON. L7R 2E3  
 Email: [staff@sclinic.ca](mailto:staff@sclinic.ca) Website: [sclinic.ca](http://sclinic.ca)

PAIN, SLEEP, ANXIETY.

|  |   |
|--|---|
| <p><b>Medical Diagnosis</b></p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div> <p>Patients must be age 19 years or older. We offer in person visits in Burlington or virtual visits with Dr. Jagmeet Sethi.</p> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <input type="checkbox"/> Consultation for Medical Cannabis: within 1 week or less.             </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <input type="checkbox"/> Urgent Consultation: 1-2 business days             </div> </div> | <p><b>Information</b></p> <p>Dr. Jagmeet Sethi MD, FRCPC Internal Medicine:<br/>             Consultation for Medical Cannabis treatment<br/>             Please use this form or your own referral form</p> <p>Dr Sethi OHIP billing is for internal medicine codes, and she does not bill FP/GP codes. Our billing codes do not impact Family Practice billing.<br/>             No fees are charged to the patient.</p> <p>We will contact the patient to arrange a virtual appointment with Dr. Sethi. Our office will notify you by fax when the appointment is booked. We do regular follow up visits. After the first visit, any cannabis related issues can be directed to us, and we will book the patient urgently if needed.</p> |
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| Patient Information         |  |                     |  |
|-----------------------------|--|---------------------|--|
| Name:                       |  | Health Card: (OHIP) |  |
| Date of Birth: (MM/DD/YYYY) |  | Street Address:     |  |
| Phone #:                    |  | City:               |  |
| Email:                      |  | Province:           |  |
|                             |  | Postal Code:        |  |

| Referring Physician Information |  |                 |  |
|---------------------------------|--|-----------------|--|
| Name:                           |  | Billing Number: |  |
| Date: (MM/DD/YYYY)              |  | Address:        |  |
| Phone #:                        |  | Signature:      |  |
| Fax #:                          |  |                 |  |