Referral for Medical Cannabis Assessment

Patient Information

Name: _____

Address: _____

Health Card #: _____

Contact Phone: _____

(Can a voice message be left at this number to schedule an appointment? _____ Yes _____ No

DOB: _____ Email Address: _____

Patient Diagnosis and Symptoms:

Previous Treatment/Medication:

Current Treatment/Medication:

Reason for Medical Cannabis consideration:

Please provide updated cumulative patient profile and medication list.

Referring Physician & Billing Number:

Address:

Telephone:

Signature:

Date:

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