



Tel: 1-866-436-7418

Fax: 1-888-362-9698

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: _____

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:

Address:

Tel:

Signature:

Date: