Referral Form for Cannabinoid Medicine

Phone: 519.339.9233 | Fax: 844.240.9273

Patient Name: _____
Date of Birth: _____
Address: _____
City, Postal Code: _____
Telephone: _____
E-mail: _____

Health Card (HC)#:
_____
HC Expiry: _____Version Code: _____
Emergency Contact: _____
Relationship: _____
Telephone: _____

Referring Practitioner: _____
Practice Telephone: _____
Practice Fax: _____
Practitioner Email:_____

Date: _____
Practice Location: _____
Billing Number:_____
Practitioner Signature:_____

Patient Medical History

- ❑ Anxiety
- ❑ Appetite Stimulation
- ❑ Arthritis
- ❑ Back &/or Neck Problem
- ❑ Cancer
- ❑ Chronic Pain
- ❑ Colitis
- ❑ Crohn's Disease
- ❑ Dementia
- ❑ Fibromyalgia
- ❑ Head &/or Brain Injury
- ❑ IBS
- ❑ Multiple Sclerosis
- ❑ Nausea
- ❑ Parkinson's Disease
- ❑ PTSD
- ❑ Sleep Disorder
- ❑ Other (please specify): _____

Goals of treatment: _____
_____
_____

Please attach FULL medication list along with previous medical history

Only completed referral forms will be accepted. Patients will be contacted by our office directly.

Thank you!