



# REFERRAL FORM

## FOR PATIENTS SEEKING MEDICAL CANNABIS

PHONE: 1 800 730 8210 FAX: 1 855 597 8500

Patient Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, Province, Postal Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Health Card #: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Billing No: \_\_\_\_\_ Signature: \_\_\_\_\_

Are you a member of a FHO/FHT/FHN? Yes  No

### PATIENT MEDICAL HISTORY

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Chronic Pain      | <input type="checkbox"/> Head &/or Brain Injury | <input type="checkbox"/> Muscular Dystrophy    |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Colitis           | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Crohn's Disease   | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> IBS                    | <input type="checkbox"/> PTSD                  |
| <input type="checkbox"/> Back &/or Neck Problem | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Sleep Disorders       |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> G.I. Disorders    | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Spinal Injury/Disease |
| <input type="checkbox"/> Other:                 |  |   |  |

### Current Medications/Treatments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Select a Clinic

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Barrie        | <input type="checkbox"/> North Bay        | <input type="checkbox"/> St. Catharines |
| <input type="checkbox"/> Belleville    | <input type="checkbox"/> Oshawa           | <input type="checkbox"/> Sudbury        |
| <input type="checkbox"/> Cambridge     | <input type="checkbox"/> Ottawa           | <input type="checkbox"/> Thunder Bay    |
| <input type="checkbox"/> Hamilton      | <input type="checkbox"/> Peterborough     | <input type="checkbox"/> Timmins        |
| <input type="checkbox"/> Kirkland Lake | <input type="checkbox"/> Sarnia           | <input type="checkbox"/> Toronto        |
| <input type="checkbox"/> London        | <input type="checkbox"/> Sault Ste. Marie | <input type="checkbox"/> Windsor        |
| <input type="checkbox"/> Newmarket     |   |   |

**Please send all relevant Medical records including specialist and diagnostic imaging reports. Patients will NOT be seen until all information has been received.**

**FAX TO: 1 855 597 8500**

**YOUR PATIENT WILL BE CONTACTED DIRECTLY**