



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

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

