Medical Cannabis Clinic

Referral for Medical Cannabis Assessment

FAX TO:
1-855-696-3534

1. PATIENT INFORMATION

Full Name:____ Health Card #:______________________

Address: ____

Telephone: ____________________________________ DOB:________________________________

2. HEALTH INFORMATION

Reason for Assessment: ___ **Pain** ___ **PTSD** ___ **Anxiety** ___ **Insomnia** ___ **Other**

Primary Diagnosis & Symptoms:

Current Medical Conditions (please provide a copy of medical records, including consults and prior treatments.

History of Psychosis **Yes/No**

List of current medications and allergies (including dosage, duration of treatment).

List of medication/treatments that have been tried for the primary condition:

3. REFERRING PHYSICIAN INFORMATION

______________________________ ______________________________ ________________

Referring Physician's Name (print) **Referring Physician's Signature** **OHIP Provider #**

Referring Physician's Direct Phone: __________________________ **Fax:** ______________________

Address: ____

NOTE: Your patient will be contacted directly to schedule an appointment. A consultation report will be provided to you after the appointment.

O Cannabis We Stand On Guard For Thee Corporation | Phone: 1-877-278-1929 | Secure Fax: 1-855-696-3534