PATIENT REFERRAL FORM

Medical Marijuana Services

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Phone #: ____________________ E-Mail Address: ____________________

PATIENT INFORMATION

Last Name:	______	First:	______	Middle:	______
Sex:	Male / Female	Date of Birth:	______	Provincial Health #:	______
Address:	______	City:	______	Province:	______
E-Mail Address:	______	Phone No:	______	Mobile No:	______

PATIENT MEDICAL HISTORY – PLEASE ATTACH RELEVANT MEDICAL RECORDS

- ☐ AD / ADHD
- ☐ ALZHEIMER'S DISEASE
- ☐ ANXIETY
- ☐ ARTHRITIS – SEVERE
- ☐ ARTHRITIS
- ☐ AUTO ACCIDENT(S)
- ☐ BACK &/ OR NECK PROBLEMS
- ☐ BRAIN INJURY
- ☐ CANCER
- ☐ CHRONIC PAIN
- ☐ COLITIS
- ☐ CROHN'S DISEASE
- ☐ EATING DISORDERS
- ☐ EPILEPSY
- ☐ FIBROMYALGIA
- ☐ GASTROINTESTINAL DISORDERS
- ☐ HEAD INJURY
- ☐ HEPATITIS
- ☐ HIV / AIDS
- ☐ HYPERTENSION
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY DIALYSIS / FAILURE
- ☐ MIGRAINES
- ☐ MULTIPLE SCLEROSIS
- ☐ MUSCLE SPASMS
- ☐ MUSCULAR DYSTROPHY
- ☐ NAUSEA
- ☐ PARKINSON'S DISEASE
- ☐ PTSD
- ☐ SEIZURES
- ☐ SLEEP DISORDERS
- ☐ SPINAL CORD INJURY / DISEASE
- ☐ OTHER

OTHER MEDICAL HISTORY

PLEASE WRITE THE PATIENTS MEDICAL CONDITION
CHOOSE FROM LIST ABOVE OR EXPLAIN OTHER.

Physician Signature: ______________________________ Date ______________