Medical Cannabis Referral

** Please provide updated cumulative patient profile & medication list*

Patient Name:	Date of Birth:
Address:	
Health Card #:	
Contact Phone:	Can a message be left? Y / N
Email Address:	

Reason for medical cannabis consideration:

Previous Treatments & Medications:

Current Treatments & Medications:

Referring Physician:	Billing #:
Address:	
Telephone:	Fax Number:
Signature:	Date:

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