



MEDICAL MARIJUANA PRACTITIONERS Inc.

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REFERRAL FOR MEDICAL CANNABIS ASSESSMENT

Please send all relevant medical records including recent consultations with specialists and diagnostic imaging reports. Patients will not be booked until all supporting documents have been received.

PATIENT INFORMATION

Patient Full Name: _____

DOB (MM/DD/YYYY): _____ / _____ / _____ OHIP Number: _____

Phone Number: _____ (Daytime) _____ (Evening)

Address: _____

Email Address: _____ Check if Rostered Patient:

MEDICAL INFORMATION

Diagnosis and Symptoms: _____

Current Treatments and Medications: _____

Previous Treatments and Medications: _____

Additional Information: _____

REFERRING PHYSICIAN

Name: _____

OHIP Billing Number: _____

Phone: _____

Fax: _____

Email: _____

Address: _____

Signature: _____