



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: _____