



## Referral for Medical Cannabis Assessment

### 1. Patient Information

First and Last Name	Veteran ID # (if applicable)	
Health Card # (include version code)	Date of Birth (YYYY/MM/DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Telephone (Home) (Mobile)	
City/Province/Postal Code	Can a voicemail be left at this number for an appointment? Send my appointment details by text message <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient Provider/POA (to contact, if applicable)	
Email <input type="checkbox"/> Send my appointment details by email		

### 2. Health Information

Presenting Symptoms (e.g. Pain/Sleep Issues/Spams)	
Current Medications/Treatments	Allergies
Has the patient ever attended a substance abuse program?	Reason for Referral
Any history of schizophrenia, bipolar, psychosis disorder?	

### 3. Referring Physicians Information

Full Name
Profession
License#
Address
Phone# Fax#
Email
Physician Signature
<input type="checkbox"/> Additional Documents Attached

### Log


Your patient will be contacted directly to schedule an appointment. A medical report can be provided upon request.

Signature of Referring Physician \_\_\_\_\_

Please email - [info@ajjaclinic.com](mailto:info@ajjaclinic.com) or fax 1-833-693-0113 or call  
1-800-310-7274