WORLD CANNABIS
ACADEMY & CLINIC

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** ☐ Male ☐ Female
Address	**Telephone** *(Home)* *(Mobile)*	
City/Province/Postal Code	Can a voicemail be left at this number for an appointment? ☐ Yes ☐ No ☐ Send my appointment details by text message	
Email ☐ Send my appointment details by email	**Patient Provider/POA** *(to contact, if applicable)*	

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 Physicans Information

Full Name
Profession
License#
Address
Phone# **Fax#**
Email
Physician Signature
☐ 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 to info@worldcannabisclinic.com or fax 1-833-693-0113
or call 905-531-2954 for questions