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? Send my appointment details by text message ☐ Yes ☐ No ☐ Patient Provider/POA *(to contact, if applicable)*
Email ☐ 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 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 _____