CAMM Clinic
www.cammclinic.ca

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Email: info@cammclinic.ca
#125, 47 Clearview Market Way
Red Deer, Alberta T4P 0M9

Marijuana for Medical Purposes Assessment Referral Form

Patient Information

Name: ______________________ ______________________
Given Name Surname

Date of Birth: ________ ________________ ______________
Day Month Year

Mailing Address: ____

______________________ ____________ ______________
City Province Postal Code

Phone Number: ______________________ **PHN**: ______________

Reason for Referral

Medical Diagnosis: ____

Previous/Current Therapies: ____

Relevant Information:

Please attach any other relevant medical records.

Referring Physician / Health Care Provider | (HCP)

HCP Name: ______________________ **HCP Prac. ID:** ______________________

HCP Signature: ______________________________ ______________________
dd/mmm/yyyy

CAMM Clinic will contact patients directly to make an appointment