MEDICAL CANNABIS CLINICS

FAX TO: 1 (844) 477-9861

Referral for Medical Cannabis Assessment

Patient Information

Name (Last, First)		Date of Birth (MM/DD/YYYY)	
OHIP #	Expiry	Telephone	
Street Address	City	Province	Postal Code

Patient Diagnosis and Symptoms

- ☐ HIV/AIDS
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Anxiety
- ☐ Cancer_____
- ☐ Depression/PTSD
- ☐ Insomnia
- ☐ Glaucoma
- ☐ Seizure Disorder
- ☐ Chronic Pain (Location)_____
- ☐ Inflammatory Bowel Disease
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Other:_____

Current and Past Treatment and Medication

Current Treatment	Current medication-Name, Dosage, Duration
☐ Physiotherapy ☐ Psychological Counseling ☐ Massage ☐ Other:_____	Over the counter (eg: Advil, Tylenol) _____ Prescription _____

Past Treatment	Past medication-Name, Dosage, Duration
☐ Physiotherapy ☐ Psychological Counseling ☐ Massage ☐ Other:_____	Over the counter (eg: Advil, Tylenol) _____ Prescription _____

Other Relevant Health Information: _____

Referring Physician

Full Name:		Referral Date (MM/DD/YYYY):
Billing Number:	Physician Signature:	Telephone:
Address:		Fax:

Please choose preferred Location

- ☐ **Toronto**-145 Front Street East, ON M5A 1E3
- ☐ **Thornhill**-180 Steeles Avenue West, On L4J 2L1
- ☐ **Telemedicine**
- ☐ **Scarborough**-1939 Kennedy RD. ON M1P 2L9
- ☐ **Etobicoke**-605 Royal York Road, ON M8Y 4G5