REFERRAL FORM

PATIENT INFORMATION:

NAME (FIRST, LAST): ______

HEALTH CARD#: __ __ __ __ __ __ __ __ __ __ VC: __ __ __ DOB - MM/DD/YYYY: ______
10 DIGITS

EMAIL (REQUIRED): ______

ADDRESS: ______

CITY: ______ PROVINCE: ______ POSTAL CODE: ______

PHONE (PRIMARY): ______ PHONE (SECONDARY): ______

PHARMACIST NAME & CONTACT INFORMATION: ______

I AM REFERRING THE PATIENT FOR:

☐ MEDICAL CANNABIS (CANNABINOID THERAPY) ☐ SUBSTANCE USE (ORT)

PLEASE ATTACH MEDICAL HISTORY (INCLUDING CURRENT MEDICATION LIST):

______

______

______

______

CONSULTANTS:

NAME: ______	NAME: ______	NAME: ______
DESIGNATION: ______	DESIGNATION: ______	DESIGNATION: ______
PHONE: ______	PHONE: ______	PHONE: ______
☐ CURRENT?	☐ CURRENT?	☐ CURRENT?

REFERRING PRACTITIONER INFORMATION:

REFERRING PRACTITIONER NAME: ______

PROFESSION: ______ BILLING# : ______

BUSINESS ADDRESS: ______

CITY: ______ PROVINCE: ______ POSTAL CODE: ______

PHONE: ______ FAX: ______

SIGNATURE OF REFERRING PRACTITIONER: ______

DATE SIGNED - MM/DD/YYYY: ______

EI-NOV. 2020