

# REFERRAL FORM



## PATIENT INFORMATION:

NAME (FIRST, LAST): \_\_\_\_\_

PHIN: \_\_\_\_\_ REG#: \_\_\_\_\_ DOB - MM/DD/YYYY: \_\_\_\_\_  
9 DIGITS 6 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: \_\_\_\_\_